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Case Management ADVISOR™

Covering Case Management Across The Entire Care Continuum

## INSIDE



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# Look to your reinsurer for help in managing catastrophic cases

*CMs should be aware of reinsurance benefits*

You're a case manager for an insurance company, and a spinal cord injury case that needs intensive management and care over a long period of time lands on your desk. You've never handled care for a spinal cord injury patient. Where do you turn for help?

• You're already juggling two difficult cases that require a lot of intervention along with the usual number of routine cases, when a third case that will require a lot of time lands on your desk. What can you do?

• You're handing a catastrophic case in a distant city but can't afford to fly in for the team conference. Who will represent your interests in planning care for the patient?

In all three cases, the answer may be the company that reinsures your health plan, says **Joann C. Milne**, RN, BSN, CRRN, PHN, assistant vice president of medical management programs with IOA Re, a reinsurance underwriting company with headquarters in Plymouth Meeting, PA.

Reinsurers have a lot of experience in dealing with difficult cases. They work nationally with a network of resources across the country and often are willing to help even before the reinsurance benefits kick in, Milne says.

"When a catastrophic case comes along, many more people than just the case manager need to know what's going on in order to provide the best clinical care with the most effective approach. There may be additional resources that are available through the reinsurer," Milne adds.

For instance, in the case of the patient with the spinal cord injury, the reinsurance company can provide the assistance of a case manager with specific experience in case management of spinal cord injuries to guide the insurance company case manager every step of the way or to actively manage the case.

"Day in and day out, reinsurers are notified of the 'worst-of-the-worst' cases nationally," Milne says. "Reinsurers assume financial risk on catastrophic cases. They are likely to know the best professional or facility to

tap into to optimize the outcomes for the difficult case the case manager is handling. Most reinsurers have access to national resources and are able to advise their clients as to which providers or facilities have significant experience and positive outcomes. When there is a catastrophic case, we know who would best be able to manage the case and, given the opportunity, we can help coordinate the access to those services."

The reinsurer often has service contracts in place to help from a financial standpoint in using those resources, she adds.

In the case of the three difficult examples, the case manager could consider tapping into the reinsurance resources and give her attention to other cases.

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## Editorial Questions

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"When an insurance case manager has several heavy cases along with the routine caseload, we can provide resources to help out with the most difficult cases. This additional support enables them to focus on their more routine caseload, those for which the health plan assumes more financial risk. This type of approach develops a true partnership," Milne says.

If you're managing the care of a catastrophically ill or injured patient in a distant city, the reinsurer may be able to get a case manager in that city to represent your interests at the team conference.

"In most cases, an insurer doesn't have the resources to fly someone into where the case is being medically managed. Telephone communication can be inadequate with catastrophic cases. If the reinsurer finds value in having an on-site presence, they will make it happen. Having someone on site can improve outcomes both clinically and financially," she says.

Within the last three or four years, reinsurers have seen a greater need to step in and provide medical management before the deductible has been met to prevent the case from going over the deductible, Milne says.

"Often the case management support services are free and are there for the taking, but our clients are too inundated with day-to-day activities to step back and ask for help," she says.

Here's another example of how the reinsurer can step in: Milne recently handled the case of a Medicare primary patient who was so chronically ill that she was in and out of the hospital to the point of exhausting her Medicare benefit. She wasn't able to maintain medical stability and stay out of the hospital for 60 consecutive days to renew her Medicare benefit. This meant the self-funded employer group would be responsible for inpatient days unless her Medicare benefits could be renewed.

The third-party administrator called IOA Re to see if it could help. The group would not authorize case management, so the reinsurer stepped in and paid for the cost of a case manager to turn the case around.

"As the reinsurer, this is a case that is going to be potential risk for us, and it appeared as though nobody was minding the shop. Someone needs to find out what's going on at home, at work, and with her current medical management to work with the patient and her provider to keep her stable and out of the hospital. It's a case of the reinsurer stepping in and saying, 'Let us help you,'" Milne says.

Health plans typically work regionally, but reinsurers handle catastrophic care across the country. Some patients may have to go out of their regional network to get the care they need. This is when a reinsurer can help.

"The reinsurer is there to provide financial resources on catastrophic care as outlined in the reinsurance contract, and they have the resources and connections to help their clients best manage the difficult cases," Milne adds.

Reinsurance contracts typically do not specify what the health plan case manager can do, Milne emphasizes.

"The health plan maintains active control over the patient's case, even though it may ultimately be the reinsurance dollars that are spent," she says.

The reinsurer does not preapprove or pre-deny care. It's there to help guide a difficult case, provide resources, and provide information to help the client make good decisions. It's up to the health plan or other reinsure client to approve or deny care, she adds.

"As the risk taker, reinsurance carriers want to make sure appropriate things happen, but in the current market, we can only advise. We can't and don't direct care," she says.

However, reinsurers do have the expertise on difficult cases and have put together extensive networks to help best manage catastrophic cases without offending the health plan.

"Reinsurance wants to do what is right. We realize that even though there may be larger expenditures of claims up front, the long-term savings are well worth it. We make sure the appropriate care is done as efficiently and as promptly as possible to minimize the long-term financial aspect of care," Milne says.

The reinsurer can act as a liaison to resources for their clients and often will pay for services with no fee to the client, she adds. ■

## What are the uses of reinsurance?

*Insurance for the insurance company*

A catastrophic case that involves a lot of coordination of resources, a lot of care planning, and a large allocation of financial resources that may or may not cause the patient to reach his or her maximum lifetime benefit should be a flag to the case manager to find out who may be sharing the risk.

Often, that means the company that provides reinsurance for the health plan. Reinsurance companies offer medical management oversight and often have the resources to help with funding that isn't available under basic care and the knowledge to help with case coordination.

"Case managers often don't understand that these resources are available. As case managers, we should be tapping into all the resources for our patients. In some cases, it would be in the best interest of the reinsurer to help out," says **Joann C. Milne**, RN, BSN, CRRN, PHN, assistant vice president of medical management programs with IOA Re, a reinsurance underwriting company with headquarters in Plymouth Meeting, PA.

Reinsurance, simply put, is insurance for the insurance company. It helps to provide a basis for financial security within an organization by protecting against the dollars involved in caring for patients with catastrophic illnesses or injuries.

Reinsurance is set up very much like personal health insurance. The health plan or party purchasing the reinsurance has a deductible that must be met before coverage under the reinsurance plan kicks in.

"It's important for case managers to know what the deductible is and what terms are set for coverage," Milne adds.

Reinsurance is designed to cover illnesses and injuries that cannot be predicted because of low frequency. Insurers base premiums on average expected claims coming in — for example, so many live births, so many appendectomies, so many heart attacks, and so forth.

After the cost of the patient's care reaches the deductible amount, the reinsurer will reimburse the client according to the agreement and begin to assume the financial risk.

"Nobody can predict the financial risk on catastrophic events because it's hard to know what will happen," Milne adds.

Some larger health plans have a lot of revenue and capital, and a $2 million case or two won't hurt them as much as it would a smaller health plan, she says.

"But if a plan with 30,000 members gets a set of triplets and care for each costs $1 million, it could affect the financial integrity of that health plan," she adds. Reinsurance plans have a deductible, typically $50,000 to $150,000, depending on how much risk the health plan feels it can manage.

When they encounter a catastrophic case,

health plan case managers should ask the director of case management if a reinsurer is involved. If the director isn't sure, ask him or her to follow up with the medical director, chief executive officer, or chief financial officer, Milne advises.

Larger HMOs are likely to be self-funded for reinsurance, she says. In that case, case managers should notify their supervisor and the chief financial officer of the company if they have a case that has the potential for consuming a lot of resources, Milne says. "The important thing is to know to ask the question."

The job of the case manager is to make sure they are doing everything they can to get all the appropriate treatment possible for their patients. The reinsurer is one avenue they can explore for resources above and beyond what the health plan can do, she adds.

"Part of the case manager's job is to act as an advocate for their patients, making sure they get appropriate treatment, timely coordination of care, and necessary funding to take care of their health care needs. The reinsurer may be a resource to case managers to help with that advocacy and afford the patient resources above and beyond what the health plan offers," Milne adds. ■

# Oncology CM vendor improves cancer care

*Result is healthier patients, lower costs*

When the quality management and quality improvement teams at Blue Cross and Blue Shield of Missouri examined the data for each disease, they found that the costs for oncology were increasing at a much greater rate than for other diagnoses and that the increases were exceeding 10% a year.

"It got our attention right away," says **Sharon Hoffarth**, MD, medical director for quality management who supervised the implementation of the oncology management program of Blue Cross and Blue Shield of Missouri. The oncology management program is a specialized utilization management program with a strong oncology case management component.

The health plan's quality management and quality improvement sections look at the ICD-9 codes for each disease annually and divide them into "buckets" to compare cost trends from HMO and PPO members, Hoffarth says.

When the oncology costs began soaring, the team starting looking for reasons and ways to improve the situation.

Like other case managers, the health plan case managers were mostly generalists with little or no specialized training to manage oncology patients.

When oncology certification requests came in, the nurse case managers and their physician advisors often had to research any new procedures or practices before making a certification determination.

"Because of the difficulties of wanting to make the right decisions for our members, it wasn't good for our members and it wasn't good for the network providers," Hoffarth says.

The company chose Quality Oncology of McLean, VA, to handle its oncology management program. The program was launched in the fall of 2002. About 2,100 members are expected to be eligible.

Quality Oncology handles utilization management and case management for members with cancer who are 18 years of age and older. Members have 24-hour-a-day access to a team of cancer nurses.

"The case management side is where we find the real value of our contract with Quality Oncology. Their nurses have five to 10 years of experience in oncology and are familiar with all the difficulties that cancer patients face," Hoffarth says.

For instance, cancer patients often need help with pain management, hydration, nutrition, and infection. A significant number face end-of life issues.

"The Quality Oncology nurses are excellent at coordinating care and helping our members with cancer stay as healthy as possible. Because potential problems are recognized earlier, these members have a better quality of life and are at lower risk of being hospitalized for complications associated with cancer therapy. The result is healthier members and lower medical costs," Hoffarth says. The biggest bonus has been the decrease in inpatient admissions, she notes.

"We've seen dramatic results. The approach to oncology management is not rocket science. It's getting people who know the terrain in touch with the patients and basically nipping any potential problems in the bud," Hoffarth adds.

Nurses with oncology experience know what can go wrong and recognize early on when a member may be developing a problem, she adds.

The oncology nurse case managers talk to members about their diet, nausea, pain, and other

concerns. Based on their conversations, they may tell the members to call the physician if the situation indicates.

For instance, if a patient is vomiting and can't keep his medications down, the oncology case manager will advise him to see the physician, possibly heading off a trip to the emergency department.

"The Quality Oncology nurses are very good at coordinating hospice care. They not only help the physician in arranging care, but they make it the best situation for the member and the member's family," Hoffarth adds.

The oncology program has benefits for oncologists, too. The certification denial rate for oncology services provided by Quality Oncology is lower than the overall denial rate — 2% compared with 5%, she says.

If a certification nurse gets a request to certify some kind of treatment that falls outside oncology treatment guidelines, they refer the quest to the Quality Oncology physician advisor. The physician advisor, who is a board-certified oncologist, immediately calls the treating oncologist to discuss the request and work out an acceptable treatment approach.

Referrals are generated from trigger reports based on ICD-9 and CPT codes, and in some cases come in on the regular certification line.

"Generally, if the utilization management certification nurse suspects cancer, we turn it over to Quality Oncology right out of the gate to work with the member's provider," Hoffarth says.

For instance, if someone is admitted for stomach pain, the case manager knows he or she needs to keep an eye out for the first signs that it may be an oncology case, she adds.

Prior to the programs launch, some network physicians expressed skepticism about the merits of the program. Since the programs has gone on line, the network oncologists seem to appreciate the service, Hoffarth adds.

In the first month of the program, a local oncologist called to suggest other Blue Cross Blue Shield of Missouri members who were not currently in active treatment. They thought these members would benefit from oncology case management.

Because the Quality Oncology nurses are oncology-trained nurses and the physician advisors are oncologists, they know what the treating physicians and their office staff are talking about, Hoffarth points out.

Before the insurer starts a new disease management program, they get input from the members of their physician network.

When they started the oncology case management program, they invited network oncologists to attend meetings held throughout the health plan's area of coverage with the corporate medical director and the Quality Oncology medical director to discuss any concerns.

"We value very highly the collaborative relationship we have with our physician network. We've worked very hard over the past six or eight year to include physicians in our planning process and to get to the point where our physicians feel they can work with us. We want to maintain an open door for our network doctors, Hoffarth says. ■

## Collaboration: Key to oncology program

*Vendor, health plan CMs work together*

When Blue Cross and Blue Shield of Missouri negotiated a contract with Quality Oncology to handle utilization management and case management services care for its members with cancer, the health plan insisted that the vendor use the insurer's system so the in-house staff would have instant access to patient data.

"The fact that everybody is entering information into the same system keeps everybody informed so there is no disconnect or duplication," says **Sharon Hoffarth**, MD, medical director for quality management who supervised the implementation of the oncology management program.

Under the terms of the contract, the Quality Oncology nurses work with the member, the member's family, and the member's provider from the time a diagnosis of cancer is suspected through the active treatment, treatment for recurrences, and hospice care when necessary. They also work closely with the patient's regular case manager.

"This way, we make sure there aren't any gaps in service, duplication, overlap, or mixed signals," Hoffarth says.

Blue Cross and Blue Shield of Missouri's in-house case managers coordinate with the Quality Oncology case managers on patients who have other chronic conditions, such as diabetes or heart disease.

For instance, if a diabetic tells the oncology case manager about problems related to an insulin pump, the oncology case manager has access to

data that enables him or her to locate the health plan case manager who is managing the diabetes and get the problem taken care of immediately.

Since they enter their nursing notes into the Blue Cross and Blue Shield electronic data system, the in-house case managers know what is going on with the patients. When the oncology case manager determines that the patient no longer needs services relative to cancer care, the health plan case manager take over.

The arrangement is seamless for members, providers, and staff.

The Quality Oncology nurse-case managers and physician advisors are linked to the insurer's computer and telephone system. When a physician calls the certification number, a prompt will tell him or her to enter a number for oncology. The physician then will be linked directly to the Quality Oncology certification nurse.

The data entered at Quality Oncology automatically becomes part of the case records at Blue Cross Blue Shield.

"Our concurrent review certification nurses work directly with the Quality Oncology nurses. They call back and forth all the time about any members hospitalized for diagnostic work-ups or treatment for cancer," Hoffarth says.

Since the insurer's concurrent review nurses follow the members' care during hospitalization, they act as eyes and ears for the Quality Oncology case managers, alerting them to what they may expect.

The oncology certification nurses are the same nurses who manage on the case management side so they know everything that happens on the inpatient treatment side and, once their outpatient treatment starts, there is no transition for the patients. ■

# Predictive modeling helps DM company focus on care

*Managing the population one person at a time*

Targeting the right members for intensive disease management is the key to a successful program, says **Christobel E. Selecky.**

That's why her company, LifeMasters Supportive SelfCare Inc., spends a lot of time crunching data to predict the likelihood that patients with chronic disease will need help managing their conditions.

LifeMasters, a disease management company founded in 1994, sells its services to health plans, employers, and government entities with the objective of reducing the cost of health care for the chronically ill population by keeping them healthy.

The program's goals are to help people change their lifestyles and to give the physicians better information about the patient with the end result of avoiding hospitalization.

"Everybody wins. The plan saves money. The physician has more information on which to base medical decisions. The patient gets better," says Selecky, chief executive officer of the Irvine, CA-based company.

Population-based disease management can be very expensive if you do the same thing for everybody regardless of the severity of his or her condition, she says.

"To make it cost-effective, you have to have some mechanism to ensure that you are delivering the right level of service to the right person at the right time. In this way, you can allocate the cost appropriately. We do manage the entire population, but we do it one patient at a time," Selecky says.

LifeMasters uses predictive modeling to develop individual profiles of people who are appropriate for disease management and creating intensive interventions for those who need the most help.

With predictive modeling, LifeMasters is able to look at past claims experience and predict which patients may end up costing money in the next few years.

"Predictive modeling means taking the information you have and trying to draw conclusions about what intervention that person needs right now and with whom you will be the most successful," she says.

LifeMasters identifies a client's chronically ill population by using claims data and other information, or the health plan can do it itself. The company manages people with cardiovascular disease, diabetes, and respiratory disease, as well as comorbidities, such as hypertension.

"Many of the people in a disease management program have more than one health problem," Selecky says.

The company identifies the population and stratifies the individuals into various levels of intervention, depending on a variety of factors. First is cost. Those whose health care costs the most are put in the highest level. People whose costs are low, about 70% of a typical population,

receive the lowest level of intervention

LifeMasters also examines pharmacy claims data. For instance, someone who is taking six or seven drugs should be in a higher risk category than someone who is on one drug.

The predictive modeling goes a step further and looks at pharmaceutical history to see if the patient regularly refills his or her prescriptions.

"We drill down on the claims, trying to build a profile of that person," Selecky says. For instance, if a person is on six drugs, has never missed picking up a refill, and understands his or her disease, that person may be on a lower level than someone who takes fewer drugs but refills them erratically.

"Over time, as we collect data from our program participants and from regular claims feeds we receive from customers and feed it back into the model, it helps us do dynamic stratification that allows us to continually move people up and down in the program based on their changing profile," she says.

For instance, if a patient seems to be getting his or her weight under control, the system flags him or her, and the health coach reassesses where the person should be in the continuum.

If patients are at a certain level or above, a LifeMasters representative calls them and does a telephone health assessment.

"This allows us to add more information into the database, such as their knowledge of their disease, their readiness to change, and any individual issues they have identified personally," she says.

Members receiving the lowest level of intervention receive phone calls a couple of times a year, a regular newsletter, and access to educational information and tools on the LifeMastersOnLine web site**.**

"We keep an eye on them and make sure they remain stable. We look at the claims on a regular basis to make sure there are no changes," Selecky says.

People on a higher level receive monitoring and education. They are assigned a health coach — either a registered nurse or a health educator, depending on the individual member's severity and needs. The patients regularly enter data into LifeMasters' database.

About half the people who are put into the high-level program need monitoring equipment. LifeMasters sends equipment such as blood pressure cuffs and scales directly to the program participants or works with the health plan to ensure they have monitoring equipment covered by their benefit plan, such as glucose meters.

The health coach teaches them how to use the equipment and provides them with a way to enter data into the LifeMasters database.

"We teach them self-care skills and act as a coach, working with them on weight loss, exercise, or whatever they need. We make sure they understand the disease and monitor what they need to be monitoring," Selecky says.

For instance, if the patient enters data that exceed the threshold set by the patient's physician, the system automatically issues an alert to the LifeMasters nurses. The nurse calls and triages what happens next, whether it's a change in patient behavior or a visit to the physician or the emergency department.

"By using our extensive database, the nurses can look at data from six months or more and compare them to what's happening now. They can point out to the patient that they had the same reaction a few months ago when they did a particular thing. It makes for a more meaningful interaction," she adds.

The program uses a completely paperless system. Nurses and health educator undergo two months of training on how to use the system.

"I get e-mails from nurses thanking me for the computer system. They feel it helps them do a better job. Health care professionals like to feel that they have a real impact on a long-term basis. Our own people work with the patient and see them get better over time," Selecky says. ■

## Regular data aid DM effectiveness

*Patients self-report via computer*

When a member of LifeMasters Supported SelfCare's disease management program weighs himself, takes his blood pressure, or blood glucose level, he dials a toll-free number, enters his personal code, and follows the computer prompts to enter the data being monitored. It all takes a minute or less.

"It's important to make data entry uncomplicated and user-friendly. This is set up so they get it done and over with quickly," reports **Christobel E. Selecky**, chief executive officer for the Irvine, CA, disease management company.

The computerized data management system is

at the heart of LifeMasters' disease management programs for diabetes, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, and asthma.

The participants are asked to enter their data on a regular basis. The system checks against a threshold set by the participant's personal physician. If the data are out of line, the system alerts the health coach, who calls the patient to find out what is happening.

About half the time, the problem is behavioral. For example, the patient ran out of medication or ate the wrong kind of food, such as something with a lot of sodium in it.

"We use that as an opportunity for real-time coaching and talk with them about the necessity of changing their behavior," Selecky says.

If there is no apparent behavioral cause for the fluctuations, the system automatically compiles an exception report and a set of treatment guidelines to the patient's physician.

The computer includes built-in logic. For instance, if a patient weighs 120 one day and 140 the next, the system asks, "Did you mean this?" If the patient replies "Yes," the nurse is notified immediately.

"Early on, people are more likely to enter data incorrectly. As they get comfortable with the system, they speed through the data entry in less than a minute," Selecky adds.

About 85% of patients use the touch-tone telephone to enter their data. "It's a simple, low-cost data-entry mechanism," Selecky says.

The company has a web page and gives patients the option to enter their data via computer.

A small number of patients use devices that connect directly to the computer and automatically enter the data. These include scales and blood pressure cuffs.

An adapter on the scale, blood pressure cuff, or glucose monitor plugs into the telephone line. When someone uses the equipment, it automatically dials up the LifeMasters database and enters the information.

LifeMasters prefers telephone or computer entry of data. "We would rather have people think about the data, rather than have it automatically entered," Selecky says.

The company is always trying to test new technology to see if there's a better way, she adds.

"If a patient has a cognitive or physical impairment which prevents them from using our regular data-entry methods, we give them the automatic monitoring equipment. We're still evaluating how to integrate this equipment in a cost-effective way and make sure that by using it, we will generate a better outcome for our customers," Selecky says.

The staff at LifeMasters say the data that participants enter via touch-tone telephone are more accurate.

"We get a lot more false-positive reports from the automatic equipment. The grandkids come over and stand on the scale or the cat sits on it," Selecky says.

The equipment is particularly useful for the cognitively impaired or physically impaired people because it gives them a mechanism to get the data to the computer. ■

# Physicians appreciate DM assistance

*Company works hard to build good relationship*

**Christobel E. Selecky** actually has had physicians thank her for sending them treatment guidelines along with information about their patients with chronic diseases.

"Instead of assuming we're telling them what to do, they feel like it's a convenience. We've had doctors say thank you," says Selecky, chief executive officer of LifeMasters Supported Self-Care Inc., an Irvine, CA-based disease management company.

When the company started offering its disease management services to health plans in 1994, the staff took pains to involve the physicians and keep them happy.

"We have to overcome years and years of resentment about medical management programs. A lot of it was about managed care in general and the thought that anyone would be questioning physician judgment. I spent 15 years at a health plan and had my share of doctors saying, 'Who are you to tell me how to practice medicine?'" she adds.

Physician involvement is a key to the success of a disease management program, Selecky asserts. "We are by no means, seeking to substitute for or replace the physician. Rather, we hope to enhance physician care by partnering with doctors to provide information. It is very important to include not only the chronically ill patients in a disease management program but his or her personal physician as well,

whether it's a primary care doctor or a specialist," she adds.

When LifeMasters starts up a new relationship with a health plan, the company's chief medical officer sets up communication with opinion leaders if it's a network model or heads of the medical groups who work with the health plan.

During their meetings, the LifeMasters chief medical officer explains the company's philosophy and reassures physicians that the company's aim is to help them, not tell them what to do.

The company sends materials to physicians as they enroll patients, telling the physicians who they have identified and what they are going to be monitoring. They give the physician the option to change the parameters of the data.

For instance, the company's disease management plan normally calls for monitoring a five-pound weight gain in a week for congestive heart failure patients, but LifeMasters will change it to two pounds, ten pounds, or whatever number the physician thinks would be best for that particular patient.

"Because we are computerized, we can do it for each patient and each physician, and it makes them feel like we're not doing cookbook medicine and that they are in control," Selecky adds.

Instead of sending the physicians a big book of guidelines, LifeMasters send them a short form of the national guidelines for the disease each time the patient's data gets outside the norm set by the physician.

For instance, when a physician receives a weight gain alert for a patient, the second page of the fax includes brief information from the American Heart Association guidelines.

The treatment recommendations are based on national guidelines. "We are not here to tell the doctors they're not practicing good medicine. We're her to provide them with a tool to monitor their patients between office visits and to provide them information so they don't have to look it up when they get an alert," she adds.

The alert enables the physicians to act quickly when a patient has a problem and to quickly decide whether they just need a change in medication or if they should come into the office or go to the emergency department.

"We find this is very important in getting physicians to buy into the program. They see this as an extension of their office. We call it decision support for physicians," Selecky says. ■

# Program targets diabetics with highest utilization

*Frequent interventions for sickest members*

When it comes to a common disease such as diabetes, "we can't manage the universe," **Giavanna Ernandes**, RN, MSN, APNC, asserts.

"My philosophy is that, although you can't reach out to everybody, you can make a difference for the sickest members," adds Ernandes, team leader for disease management at Horizon/Mercy, a Trenton, NJ, health plan for the publicly insured.

Horizon/Mercy has had a population-based diabetes program in its quality department for years but realized that it was impossible to closely manage all 10,000 diabetics in the plan.

"We moved the program to case management and clinical operations to expand it and make it more clinically intensive. We're operating on a disease management model and are managing those who need the most help rather than just taking care of the entire population," says **Pamela Persichilli**, RNC, director of clinical operations for Horizon/Mercy.

The diabetes program started with the highest utilizers of health care resources based on hospital admissions, emergency department visits, and pharmacy claims.

By researching the data, they identified members who had more than $1,000 in claims in a year. In the first five months of the program, 803 members were enrolled.

When a member with diabetes is identified, the case managers conduct a risk assessment and health assessment to determine which ones should be targeted for the program.

The members who are not at highest risk receive population-based disease management that includes health education and targeted mailings, such as reminders to get a flu shot.

The case managers focus on the top 20% of the sickest patients, providing them with visiting nurse services, transportation to physician visits, and intensive health education.

"We focus on the sickest of the sick. We can't take care of the entire population. We have a lot of members who are doing well and don't need our help," Ernandes says.

The case managers make outreach calls to the members, giving them basic diabetic education and providing glucometers or other supplies if

the members need them.

If a member has frequent admissions and is not being seen by an endocrinologist, the case managers call the primary care physician and suggest a referral.

The case managers review members' laboratory reports, looking especially for elevated hemoglobin $A_{1C}$ levels.

"We call everyone with a level over a 7 because this means the member has not been maintaining glycemic control," Ernandes says.

The case managers educate the members about foot care, nutrition, and the importance of complying with their prescribed medications and regimen.

They make sure they have a glucometer and are seeing a physician who can help them manage their disease.

If the members don't understand how to check their blood sugar level or give themselves insulin, the case managers arrange for the visiting nurse service to help them. The case managers tell the members that the elevated levels will result in hospital admissions down the road.

They monitor pharmacy claims to make sure patients are filling their prescriptions.

"With diabetes, we like to see more claims. It shows us that they are taking their medication, and that's a good thing. Higher pharmacy claims mean that inpatient admissions should be lower down the road," Persichilli says.

Because Horizon/Mercy's members are publicly insured, they are at high risk because of social and environment issues in addition to the disease. "Diabetes is a complicated disease process. Most of our patients have cardiac problems and other comorbidies as well," Ernandes says.

The program uses the American Diabetes Association guidelines as the basis for its program.

"We needed to take a more targeted, more consistent, almost regimented approach to getting everybody involved," Persichilli says, adding, "education is great, but sometimes you need interventions to make education work."

Persichilli credits the administration of Horizon/Mercy for recognizing the return on investment for their disease management programs.

"In the early days, we didn't have the data, but now the data are there to support case management and disease management as affecting the bottom line. It's not just something nice to do or something to promote your health plan. It produces real results, better outcomes, and better member satisfaction," she says. ■

# Little things indicate a patient has depression

*Diagnosis is common in the chronically ill*

A patient whose chronic illness you are managing is not likely to tell you that he or she is depressed.

Instead, you may hear little comments here and there that indicate something is going on with the patient besides just the physical illness, says **Sam Toney**, MD, a board-certified psychiatrist and founder of Tampa, FL-based CMS Healthcare Integrated Inc.

"What the nurse case manager often will hear is little cues. The member doesn't come out and say they're depressed. Instead, little things may trigger the case manager's thought process," Toney says.

Members may say, "I feel tired all the time," or "I don't feel like doing anything."

Or they may comment that they don't see any reason to do a certain thing any more.

For instance, a patient may tell the case manager that he no longer enjoys going to baseball games to see his grandson play.

"In general, case management nurses have a good feel for the patient because of the one-on-one relationship they develop with the patient. They are in touch with everything that's happening with the patient," Toney says.

## *Common comorbidity*

Depressive disorder is a fairly common disease that should not be taken lightly. "The literature suggests that with most chronic illnesses, the rate of a depression comorbidity is 25%-35%. We are beginning to see that there is in fact a high frequency in our chronically ill patients," he says.

Undiagnosed and untreated depression makes complying with a disease management plan an uphill battle, Toney adds.

"If a disease management program is treating only the disease and not the entire person, you lost the opportunity for an increased impact," he says.

Case managers whose contact with patients is by telephone must have great listening skills, compared to the clinician in the office sitting face-to-face with the patient.

"Half of the cues the case managers receive are from intonation or the way the patient responds to questions. It's amazing how nurses can pick up on that," Toney says.

The CMS integrated care system combines case management and disease management of both medical and behavioral conditions.

The computer-based system includes a depression screen that case managers can apply when a member mentions something that may indicate depressive disorder.

The nurses may discuss the case with the CMS medical directors or talk to the patient about being evaluated.

"Some members are not as open as others to the concept of having depressive disorder. Because case management is a one-on-one relationship, the nurse can choose the right direction. Depending on where we are in rapport, the nurses talk to the patients about opening up the possibility of being evaluated for depression," Toney says.

### *Depression screening*

The CMS nurse case managers are trained to stress the fact that chronic and catastrophic illnesses can have a devastating effect on the body, including the central nervous system, which can lead to a chemical imbalance and illness.

"We've had very good results with that approach. We've had the patient open up to the possibility of being evaluated for a confirmatory diagnosis," Toney says.

The CMS depression screen picks up the possibility of a diagnosis of depression.

"It enables the primary care physician to look at the possibility of depressive disorder without having to refer the patient to a behavioral health professional in case there is resistance," Toney says.

The next step is to confirm the diagnosis and then look at the appropriateness of enrolling the patient into the program, Toney adds.

"When the case managers pick up the cue from the patient that things aren't going the way the patient would like, they can switch very quickly to the depression screen. They can word the questions in simple lay terms so that members will answer in a way that they don't realize they are defining that they are depressed," says **Cheri Lattimer**, RN, the company's vice president of medical management.

For instance, the progression of questions may be:

**Patient:** I'm so tired all the time.

**Case manager:** Are you having trouble sleeping? Do you think it's not related to your diabetes?

If the patient answers yes, the nurse goes on to ask questions about whether the patient has problems eating that might not be related to their disease and if they are enjoying things less.

"We created it to be a nonthreatening screening but one that would provide enough information so that the case manager can take it to the physician," Toney adds.

CMS case managers are not necessarily from behavioral health backgrounds. Their specialties run the gamut from heart disease, diabetes, and cancer.

"But they can pick up cues that something else is going on, and this gives them the support to evaluate the need for a further assessment," Toney says.

The CMS system includes a list of questions that indicate a risk of a comorbidity of depression if the patient answers them positively.

When this occurs, the system puts in a task list that enables the nurse case managers to continue to monitor the target patients.

"These are the tools that the nurses need today. There are so many patients and so little time, but our system literally keeps them moving and constantly evaluating," Toney says.

CMS was developed to integrate medical and behavioral health care, Toney says.

"Case managers do a wonderful job of identifying patients and getting them into the most appropriate level or care, but there are a lot of gaps between the systems and tools. They need a system that enables the claims side and the network side to function together efficiently and effectively," he adds. ■

## *COMING IN FUTURE MONTHS*

- How to ease the transition when elderly patients can no longer live at home
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# CE questions

*For more information about the CE program, please contact customer service at (800) 688-2421. E-mail: customerservice@ahcpub.com.*

9. Reinsurance is designed to cover illnesses and injuries that cannot be predicted because of low frequency.
A. True
B. False

10. At Blue Cross and Blue Shield of Missouri, what is the certification denial rate for oncology services provided by Quality Oncology?
A. 1%
B. 2%
C. 3%
D. 4%

11. Members of LifeMasters Supported SelfCare's disease management programs report data via which of the following methods?
A. Touch-tone telephone
B. An Internet web page
C. Devices such as scales and blood pressure cuffs that connect directly to a computer
D. All of the above

12. After reviewing members' laboratory reports, case managers with Horizon/Mercy's diabetes program call all members with a hemoglobin $A_{1C}$ level of what?
A. Above 3
B. Below 3
C. Above 7
D. Below 7

**Answers: 9. A; 10. B; 11. D; 12. C.**





## 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. ■

# Reports From the Field™

## Plan knowledge affects how consumers look at cost of drugs

Consumers' drug-buying behavior may be based on how much they know about their personal health care coverage, a Harris Interactive survey reveals.

According to the survey, consumers with low levels of knowledge about their coverage appear to be less price-sensitive when they fill prescriptions, while those who more thoroughly understand their health coverage are more concerned with price.

The survey showed that more than a third of consumers said they didn't know how their copays were structured.

Only 16% reported that they almost always or often ask their physicians whether the medications are covered by their insurance. Only 4% had changed their prescription plan because a specific drug was not covered.

When presented with the option of a cheaper drug, nearly 60% chose to stay with the more expensive drug. Of those consumers who chose the cheaper drug, 98% said they would change for a price difference of $10 or less. ▼

## Musculoskeletal conditions, mental health impact productivity

Musculoskeletal conditions, including arthritis, low-back pain, repetitive motion strain, and mental health problems — mostly depression — have the biggest negative impact on worker productivity, according to a survey by the Institute for Health and Productivity Management (IHPM), a nonprofit research organization in Scottsdale, AZ.

The organization surveyed 34 employers with a total of 1.2 million employees.

The survey asked workers about the cause of absenteeism and the health and disease issues that diminished their performance at work. Pregnancy was the third-leading cause of absences from work.

Few of the employers surveyed offer disease management programs for musculoskeletal conditions or mental problems, the report says.

"If more employers established disease management programs to deal with these health issues, they would be able to reduce their overall health-related costs while increasing productivity," says **Scott Sullivan**, president and CEO of IHPM. For more information on the IHPM, see its web site at www.ihpm.org. ▼

## Physicians report frustration with managed care red tape

Sixty percent of physicians responding to a survey by the Pennsylvania Medical Society expressed frustration with eroding patient-doctor relationships and blame lack of time for the problem.

The survey of 330 physicians revealed that they spend an average of 12 minutes with each patient, and 40% say they spend less time with their patients than when they first started practicing medicine.

Many of the physicians blame HMOs and managed care for the lack of time they have to spend with their patients. They also cite economic

pressures caused by declining reimbursements as the reason more patient visits must be crammed into their office hours.

More than 80% reported that they aren't fully reimbursed by insurance companies, leaving them with less revenue to attract and keep employees and buy the latest medical equipment.

"Having to generate more money due to decreased reimbursements by the insurance company is the primary cause of decreased patient time," wrote one physician, who reported that one insurance company decreased reimbursement by 8%, and his medical liability rates went up $100,000 a year.

Physicians also cited managed care red tape, such as increased documentation requirements, as a cause of decreased time they spent with patients.

Despite the frustrations, 67% said they would become physicians all over again. They cited the chance to help people and gratifying relationships with patients ahead of money or prestige as the reason to become a physician. ▼

## White paper addresses HIPAA concerns and DM

A comprehensive analysis of the Health Insurance Portability and Accountability Act (HIPAA) and its impact on disease management has concluded that the new privacy regulations will not hamper disease management programs, according to the Disease Management Association of America (DMAA).

The association's White Paper concluded that the Department of Health and Human Services has fully safeguarded the ability of legitimate disease management programs to use and disclose protected health information for activities within the DMAA's industry consensus of disease management.

These include enrolling and engaging patients, teaching patients self-management, coordinating care, providing medication compliance guidelines and reminders, publishing outcomes data, conducting population management and risk stratification, supporting physicians and the plan of care, and promoting other disease management and population management services.

"While a lot of things in HIPAA are still unclear, disease management is not one of them. The White Paper's legacy will be to eliminate any concern that disease management cannot coexist with strong patient privacy protections, that disease manager somehow hinder or is hindered by privacy. Neither is true, and this initiative finally proves it," says **Warren Todd**, DMAA's executive director.

The document may be obtained free from DMAA. See the web site at www.dmaa.org. ▼

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## Send us Resource Bank items

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

Send items for publication to Mary Booth Thomas, Editor, *Case Management Advisor*, P.O. Box 740056, Atlanta, GA 30374. Phone: (770) 934-1440. E-mail: marybootht@aol.com.

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