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Depression management program encourages timely care

HEDIS scores rise in several areas

A comprehensive approach to depression management has paid off for Health Alliance Plan (HAP), a Detroit-based HMO. The Depression Disease Management program includes educational mailings for members, behavioral health case management, a partnership with physicians, and an adjunct program that helps identify people with congestive heart failure and diabetes who are at-risk for depression. A similar program helps identify new mothers who are at risk for postpartum depression.

Collaboration between departments at HAP is a key element of the program. The Quality Management Department handles oversight of the disease management program in partnership with behavior health case managers in the coordinated behavioral health management (CBHM) department and HAP's traditional case management department.

"It's open-ended. We are all part of the same health plan, and we have a software system that allows us to communicate with each other and perform case management [jointly]," says **Mary Clare Solky**, MA, director of CBHM.

Dealing with behavioral problems

Managing care of patients with behavioral health issues is a major concern these days. Research has shown that patients who are depressed and those who don't take their medication for psychological disorders are hospitalized frequently and have higher health care costs than the norm. In this issue, we'll show you how a health plan screens patients with chronic disease for case management and why it also screens new mothers. You'll learn how to maintain patient confidentiality in a depression management program and how to get help in setting up your program. We'll give you tips from an expert on how to improve compliance for patients on antipsychotic drugs.

For instance, members who are in HAP's other disease management programs are screened for depression, referred to a behavioral health specialist in some cases, and enrolled in the Living Well with Depression program. **(For details on the screening, see related article on p. 51.)**

New mothers receive a depression screening questionnaire in their postpartum packet.

Here are some of the plan's achievements:

• According to HEDIS 2000 figures, 92% of HAP's commercial patients who were hospitalized for mental illness saw a counselor within 30 days of discharge, up from 86% the previous year.

• Two HEDIS measures that gauge adherence to prescription regimes for depression management have increased during the past two years since the Depression Management Program was implemented.

• HAP achieved the national best practice for HEDIS 2002 rates for Follow-Up after Hospitalization for Mental Illness within seven days of discharge with a score of 84.95%.

About 21,000 members who have been diagnosed with depression are enrolled in HAP's Depression Disease Management.

Members who have been diagnosed with depression receive an introductory letter telling them about the depression disease management program, called the "Living Well with Depression" program and offering them an opportunity to opt out, says **LaShawnda Cash**, MPH, depression management coordinator in HAP's quality management department.

"We have set up the program so members can opt out easily if they want. In the two years of the program, only about 250 of the 21,000 members identified with depression have chosen to opt out," she says.

If they don't opt out, they receive educational material and a depression management toolkit that includes extensive information about the disease, information about antidepression medication, and a reminder log that members can use to write down the times and days they take their medications.

They are offered a variety of additional educational pieces on topics that include depression and obesity, depression in the elderly, depression and medication, and coping with a loved one's depression. They can send in a card ordering the additional materials or access them on-line.

Members in the Living Well with Depression program also receive a quarterly newsletter addressing various subjects in which the members may be interested. For instance, the next issue features information on stigmas associated with depression and how the members can cope with them.

This year, members diagnosed with depression and on antidepressant medications will get medication reminder letters with information on prescribed medications, the recommended length of time they should take their medication, and the importance of following up with their physician.

When an HAP member is hospitalized for depression, the behavioral health case managers, masters-prepared behavioral medicine clinicians, step in.

There are 12 case managers in the CBHM department, each assigned to certain physician

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Editorial Questions

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

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Screening identifies members at risk for depression

Initiative is to improve members' quality of life

When members enroll in one of Health Alliance Plan's (HAP) disease management programs, the health assessment questionnaire they fill out includes trigger questions that may indicate that the member is at risk for depression.

"We include theses questions because there is a higher instance of depression with other chronic illnesses. Those who answer positively to the trigger questions are mailed a depression screening questionnaire to fill out and send back," says **LaShawnda Cash**, MPH, depression management coordinator in HAP's quality management department.

The organization has developed disease management programs for asthma, diabetes, and congestive heart failure.

Members in HAP's disease management programs fill out an initial assessment that has two depression "trigger questions." If they respond positively to those questions they are sent a Prime-MD Depression screening tool to fill out and mail back. The screening tools are scored and reviewed by case managers in the coordinated behavioral health management (CBHM) department.

One of the behavioral health case managers calls members who respond to the second screen and discuss the results. They talk to them to find out what is going on in their life and offer them an appropriate type of intervention.

"Some of the feelings of depression are related to their illness. The case managers spend time with them and educate them about their illness. They try to get them to accept a referral to a specialist, even if it's just for an evaluation," says **Mary Clare Solky**, MA, director of coordinated behavioral health management.

The case managers tell members that if they get professional help for their depression, it can improve their quality of life and help their other illnesses, she adds.

If the members are diagnosed with depression, they also become part of the Living Well with Depression program.

Members have responded well to the case managers calls, Solky reports.

"People like it. They are surprised at how the departments are connected, and they like knowing that the plan is looking at them as a whole person, rather than just the diabetes or asthma," Solky says.

Helping patients with chronic illnesses cope with depression improves their compliances in their treatment plan and helps prevent exacerbations, she adds.

"We try to cover all angles and take every opportunity to make sure our members are getting the right type of care. There is some speculation in the literature as to whether or not total costs of care go down when patients get proper behavioral medicine care. However, we are assured that the patients are getting the right care and that their quality of life is improving," she adds. ■

groups so patients always are seen by the same case manager.

Case managers provide care for members who need specific help with managing their depression, and sometimes follow them for years.

They contact patients to ensure that they get a post-discharge follow-up with a behavioral health professional within seven days of discharge.

"The case managers will work with a member until he or she has had a follow-up appointment," Solky says.

They call to remind the patient to go to the appointment and check with the physician to see that it was kept.

If someone is admitted to a hospital with depression, the behavioral health case managers give him or her intensive interventions.

"We all work hand in hand. The case managers ensure they are enrolled in the Living Well with Depression program if they have been diagnosed with depression," Cash says.

The plan sends its primary care physicians HAP's depression clinical guidelines and other tools, such as office screening materials and panel reports on the patients they have diagnosed.

The reports include information such as the date the patient was diagnosed, prescriptions that have been filled, and visits to any other providers.

Working with and educating physicians is one of HAP's major initiatives this year, Cash says.

"Some members who have a diagnosis of depression and are taking an antidepressant contact us to tell us they don't have depression," Solky says. "Sometimes, it's hard for them to hear that they have depression. Other times, their provider determines that it's in their best interest not to know."

The health plan wants to encourage physicians to educate their patients about their diagnosis of depression. In the past, patients often were not informed of their diagnosis, she adds.

HAP representatives visit the offices of primary care physicians and behavioral medicine

practitioners to make sure they are using the information they have received and to make sure patients' care is being coordinated.

The insurer is working with other local insurance plans, physicians, and employer groups to develop clinical practice guidelines and other forms to assist physicians in identifying and managing patients with depression. This partnership allows one common message to be sent to all providers regarding appropriate, evidence-based treatment recommendations.

This year, HAP is focusing on developing and implementing a program to place some patients with higher levels of depression, who have not been hospitalized, in a more proactive case management program.

These case managers would telephone the members at intervals, possibly go to therapy appointments with them, and work with them and their families by telephone and in person.

"Once someone is diagnosed with depression, if it's not treated properly and for enough time, the cases of remission and reoccurrence are very high. When someone has one episode, the chance of another episode is high," Solky says.

The case managers will help them recognize the warning signs so they can get help quickly rather than slipping into deeper depression.

"In most cases, the longer someone waits for treatment, the longer it will take to get the disease under control," Solky says.

The health plan also is working on ways to identify members who are undiagnosed or undertreated, Cash adds. ■

Program targets postpartum depression

Aim is to avoid problems down the road

Health Alliance Plan (HAP) takes a proactive approach to postpartum depression, screening all new mothers within two to four weeks of the birth.

New mothers are mailed a postpartum packet with the Edinburgh Postpartum Depression Screen Prime-MD screening tool included, which is mailed back to the health plan's coordinated behavioral health management (CBHM) department to be scored and for follow-up.

The intervention is timed so that women at risk for postpartum depression can be identified before they see their obstetrician for their six-week check-up. Postpartum depression usually does not set in until two to four weeks after the birth.

"It's a high-risk population, and there can be tragic circumstances if postpartum depression isn't treated," says **Mary Clare Solky**, MA, director of coordinated behavioral health management for the Detroit-based health plan.

The behavioral health department scores the screening information. A case manager calls women whose score exceeds a certain threshold and suggests that they see a behavioral health specialist.

If the new mothers don't respond, the case managers follow up and send them a second letter if necessary.

"Women are very receptive to getting help. We do a lot of intervening," Solky explains.

The behavioral medicine case manager is the lead person working with postpartum depression members. They make sure women with a high score are referred to a specialist and then follow up to make sure they go to their appointment. ■

Depression program maintains confidentiality

Reminder calls increase patient compliance

When Buffalo, NY-based Univera Healthcare decided to include depression management in its array of population-based disease management programs, the quality management staff were concerned about preserving patient confidentiality.

"Because depression is such a sensitive area, we didn't want to use the same approach we do in diabetes or immunization management. We didn't automatically identify everyone in the population because we didn't want lists of patients with depression floating around," says **Kathleen Curtin**, NP, MBA, vice president of quality management administration for Univera Healthcare. Univera has recently merged with Excellus Inc., now its parent company.

With the help of researchers from Dartmouth College, the health plan hit on a simple idea: instead of coming up with lists of their members diagnosed with depression, the plan began notifying prescribing physicians when patients failed

Research organizations can help you develop DM programs

Make a commitment before beginning

If you work for an HMO with a computer system that tracks patient data, you may be able to take advantage of a research organization's expertise to help you develop programs to better manage your patients.

That's how Univera Healthcare in Buffalo, NY, got the help it needed to develop a population-based depression management program.

Confidentiality was a crucial concern of the Univera staff. They wanted to come up with a way of helping their members become compliant with their medication but without compiling lists of patients being treated for depression and possibly violating patient confidentiality.

"We had created population-based programs for diabetes, heart disease, and asthma but weren't as concerned about confidentiality issues in those designs," she says.

Researchers at Dartmouth College had a grant to work on medication compliance programs and needed a source of patients for their project. They were willing to help Univera develop its depression disease management program.

"This design and our understanding of the impact of the phone calls came from our relationship with Dartmouth. We learned from the experts how to design and test this model," says **Kathleen Curtin**, NP, MBA, vice president of quality management administration.

Partnering with research institutions and other organizations is a great way to develop programs to improve patient care, she adds.

"It takes a lot of work on your part, but it's worth it because it can really enhance your programs," she adds.

Here are some other tips from Curtin on developing a successful program:

- Don't just rush into a program. Take time to plan it.
- Make sure you have a commitment from your organization to provide the resources you'll need.

"A phone call to patients three or four times over a 12-month period is a simple thing to do, but it does require resources," Curtin says.

- Make sure everything you need is in place before your start.

A successful program requires design work, creating a database and a system for calling, and training staff, she adds.

- Be prepared to evaluate and assess your program and make changes if necessary. ■

to refill their antidepression medication.

"The patient is already being cared for by the physician, so there is no breach of confidentiality when we send them a computer-generated letter," Curtin adds.

One goal of the program was to ensure that patients refill their antidepression medications. Health plan officials know that it usually takes several weeks for antidepression medication to have the intended effect.

If patients fail to take their antidepression medicine and their disease is not controlled, it can significantly reduce their quality of life and may lead to high and often unnecessary health care utilization.

Often a simple reminder can work wonders. For instance, in a pilot project, patients who received three or four brief telephone calls from nurses over a six-month period showed a 30% improvement in refilling their prescriptions. Here's how the depression management program works:

The quality management department and the pharmacy benefit department at Univera identify patients who have picked up their first prescription for antidepressants but have failed to get it refilled.

The physician who wrote the prescription, usually either a psychiatrist or a primary care physician, receives a letter explaining the program and the list of patients who failed to get their prescription refilled. The letter includes information about recognized standards of care and medical literature that suggest that newly diagnosed patients be on antidepression medicine for at least six months.

"We notify them first that literature recommends maintaining the patients on therapy for six months, and then we let them know when the patient is not being maintained on therapy," she adds.

The health plan suggests that the physicians follow up with their patients by telephone or letter and let them know the importance of consistency in taking antidepression medicine. If the physicians have a question about patients on the list, they can call a toll-free hotline for clarification.

Physicians are encouraged to refer patients to the Care Calls Program, which includes scheduled telephone calls to make sure overall depression

therapy is going well. Physicians have responded positively to the program, Curtin says.

"In an entire community, physicians get a letter listing only one or two patients each month. They remember the patients and want to follow up," she says.

When a Care Calls nurse receives a referral from a physician, she calls the patient to make sure that patient is taking the medication as prescribed and is keeping scheduled appointments.

The nurses typically call patients three or four times over a six-to-12-month period. They have been trained to understand that they are making a simple reminder call and that they shouldn't try to do therapy over the telephone, Curtin says.

"We don't have the resources for intensive management in our Care Calls program. We have a case management program to provide that service for complex patients. The nurses understand that we are organized into different levels of care, each with its own interventions," she says.

Univera's case management program for complex behavioral health patients is an adjunct to its population-based program. The complex case management program is for member with complex needs or comorbidities and is run by the behavioral health department.

The intensive program is traditional case management for complex behavioral health patients. This includes telephonic interventions that are tailored to each individual based on their treatment plan.

Many of these participants are diagnosed when a Univera member is hospitalized with a mental health-related diagnosis. The case manager monitors the patient's progress in the hospital, participates in the discharge plans, and encourages follow-up appointments with a behavioral health counselor.

The health plan has always had a case management program for complex mental health patients. The other two levels of care have been developed within the past 18 months.

The intensive behavioral health case management program has been in effect for some time. Univera developed the two other levels of care programs in the past 18 months when their HEDIS performance measures showed a need to improve in the areas of short-term and long-term medication therapy.

The HEDIS results from the first year of the programs are not yet available, but based on outcomes from a pilot program, Curtin expects to see overall improvement, particular for participants in the Care Calls program.

Before rolling out the program to the entire population, Univera conducted short-term pilot projects of three to six months' duration for all three components of the depression management program.

The design team that initiated the program looked at the pilot and decided how to roll out the full program and will make any necessary modifications to the program.

"We are interested in seeing the impact on our HEDIS scores. If there has been no impact, we'll have to make significant changes," Curtin says.

One of her goals for the coming year is to increase the number of referrals that physicians make to the Care Calls program.

"We found that this could be a powerful intervention that worked very well in the pilot project. We are going to start selling this concept to physicians so we can generate more referrals," she says. ■

Boost compliance for patients on antipsychotics

Work closely to make sure they get every dose

Patients with psychological disorders who have been prescribed anti-psychotic drugs, such as mood stabilizers, may really want to take their medication as prescribed but need a lot of help to do so, asserts **Dawn Velligan**, PhD, associate professor at the department of psychiatry at the University of Texas Health Science Center at San Antonio.

She is lead researcher on a five-year study funded by the National Institute of Mental Health to determine adherence to oral antipsychotic medications.

If these patients don't take their medication, about half will end up in the hospital within three to nine months.

"Most are wiling to take it but are doing a bad job," Velligan says.

Case managers who handle care for patients on antipsychotic drugs should bear in mind that when patients say they are taking their medication, that is an indication that they are willing to take it but it doesn't mean they are in full compliance, she says.

Among the first 70 patients studied, at three

months, measuring blood level data, only 23% are taking their medication correctly. By pill count data, only 40% are taking a reasonable amount.

"Adherence rates are very low despite the fact that 55% of patients say they take every course the doctor prescribes," Velligan adds.

She suggests that case managers have in-depth discussions with the patients about when they take their medicine, where they keep it, and what kind of reminders they have in place. Give them regular reminder calls to take their medicine.

Also, help them work on ways to improve compliance. For instance, if they usually forget their dose at night, give them a pill container and a bottle for water to put on their bedside table.

If you see the patients in person, set up pill containers for them and have the patients bring them back to every visit.

Patients taking antipsychotic medications have a number of problems that contribute to noncompliance, Velligan says.

They don't have a daily routine, so they can't anchor taking medication to a specific time, such as when they get up, when they go to bed, or mealtime.

Many of the prescriptions call for doses at 8 a.m. and 8 p.m. Many of these patients sleep until 3 p.m. and miss every morning dose. "When they're awake, they're doing what the doctor says," Velligan adds.

"What is really clear is that these patient forget or are distracted, or are too tired at night to take their evening dose. There are a lot of things in the environment that are really barriers to medication," she says.

There also are system barriers. For instance, Medicaid has a cap on the number of prescriptions it will cover. If someone is on multiple medications for diabetes and schizophrenia, he or she may not be getting the needed medicine because it isn't covered.

For her research project, Velligan goes into patients' homes and sets up things so it will be easier for them to take their medication.

"Most don't have calendars or watches. We give them pill containers and special alarms where a recording of their own voice reminds them to take their medication," she says.

When patients get out of the hospital, the researchers monitor them closely for two weeks, watch them take every dose of medication, and get a baseline blood level.

They wait three months before seeing the patients again, then show up unexpectedly, take blood to check the blood level, check pharmacy records, and check the pills remaining in the house.

In the first check, the researchers found that only four of 70 patients were taking their medicine absolutely correctly, but most were taking at least some of their medicine.

Researchers also learned that patients who are discharged to boarding care homes miss their medication unless they stand in the facility's medication lines.

Among the initial patients in the study, patients in boarding care facilities got about 60% of their medications. As a result, 25% were readmitted to the hospital in the first three months after discharge, and 10% ended up in jail.

Many patients who are taking the older antipsychotic medications quit taking them because of their side effects.

Pharmaceutical companies claim that the newer generations of drugs don't have as many side effects, which should improve adherence, but that hasn't happened, Velligan says. Studies have shown that, even with the new medications, the compliance rate is about 50% to 60%.

"The number of days the patients are failing to take their medication is slightly better with the new medications, but it is still very bad," she says. ■

Initiative achieves high return on investment

CMs coordinate care through the continuum

A combination of short- and long-term case management coupled with an intensive disease management program has paid off for CIGNA Healthcare.

CIGNA reports a 5:1 potential return on investment for case management services on actively managed cases.

In addition to its Well Aware disease management program, CIGNA has on-site review nurses in hospitals and CIGNA nurse case managers who manage the care of patients needing more intensive interventions.

"We want to make sure our members get the care they need, whether it's long-term or short-term case management, whether they are well or in the hospital," says **Joy Bazo**, RN, CMC, LHRN, on-site nurse manager for CIGNA at three hospitals in the Tampa Bay, FL, area.

On-site case managers help coordinate hospital care

Timely discharge is one goal

When a CIGNA member is hospitalized in Tampa Bay, FL, he or she is likely to get a visit in the hospital from **Joy Bazo**, RN, CMC, LHRN, on-site review nurse for CIGNA in the Tampa Bay area.

Bazo is one of CIGNA's on-site nurse reviewers, based in major hospitals in major cities across the country. She covers three hospitals in the Tampa Bay area and generally makes 20-24 "patient touches" a day.

Her goal is to make sure that patients get what they need in the hospital and that discharge needs are met when they're ready to leave the hospital.

"It make a significant difference in discharge when someone proactively works with the member and their physician," Bazo says.

She visits the members within 24 hours of admission. The exception is patients having pre-planned surgery who already have received a pre-operative letter describing what will happen and their anticipated length of stay. She visits those patients the day after surgery.

"When I work with the member, I look for quality issues, such as complication from treatment, or a treatment or test that was prescribed but not done. It is a part of CIGNA's overall quality management, Bazo says.

She checks in to make sure their discharge needs have been met and to determine if they have an unexpected problem that means they should be referred to CIGNA nurse case managers for a longer-term intervention.

Bazo also conducts short-term case management for patients who need a little more attention after discharge. For instance, she makes a post-discharge call to see that home health or other services recommended by the physician are in place.

If someone is seriously injured, she looks ahead to determine anything they may need long term.

For instance, if a member is going to need wound care after discharge, Bazo sets up a home health evaluation. She looks at what supplies are needed and what should be in place when the member is discharged.

Bazo makes it a point to talk to members about the course of treatment prescribed by their physician each time she speaks to them. "If there is something new going on or the member's condition has changes, we go from there," she says.

She is proactive with physicians, asking them what the member may need after discharge and whether those needs should be set up in advance.

"If I can set it up ahead of time, it's one clerical thing that the doctor doesn't have to worry about any longer," she adds.

Case managers who are going into the hospitals should be diplomatic but also proactive for the members they represent, Bazo says.

"It's not an adversarial relationship, but working together takes development, mutual respect, knowing to ask the right question, and making yourself available to the treatment team as well. I tell people I put the Midas touch on coordinating for my patient needs," she says. ■

CIGNA's multifaceted case management program is the result of the health plan's goal to meets its members' needs throughout their lives and across every continuum of care, Bazo says.

For example, a child with asthma initially is referred to the Well Aware disease management program. If he ends up in the hospital, an on-site case manager such as Bazo is likely to visit and work with his family in planning what he should do after discharge. If he's hospitalized more than three times, he's referred to the in-house case managers for intensive case management after discharge.

"There is good synergy among all three programs — the on-site review nurse, the CIGNA nurse case manager, and the disease management programs. Our focus is on total health. The goal is for our members to stay healthy so they won't be back in the hospital," adds **Colleen Meicke**, RN, CCM, a CIGNA in-house case manager based in Tucson, AZ.

Bazo typically visits the patients in the hospital, helps ensure the member understands the care prescribed by the physician and treatment team, talks with their physicians and treatment team, helps coordinate discharge needs and goals, and makes referrals to other CIGNA programs or to community resources based on the recommendation of the member's physician. **(For more details on the on-site case management program, see above story.)**

Her goal is to see members within 24 hours of their hospitalization. If members are having pre-planned surgery, Bazo visits them the day after surgery.

"I look at whether they will need short-term or long-term case management, depending on the disease process, and make those referrals to case management so we can coordinate even from the

A proactive approach to case management

Nurses try to anticipate needs down the road

Colleen Meicke, RN, CCM, a CIGNA case manager based in Tucson, AZ, takes a proactive approach to caring for her patients, looking at what their needs are likely to be down the road.

She works with physicians and other providers, the family, and community agencies to make sure the patient's needs are met.

Here's an example of how the proactive approach works:

A primary care pediatrician, with whom Meicke had consulted, expressed her concern about a young child with a debilitating disease. Although the child still was functioning independently, the physician was concerned that the family wouldn't have the services it needed as the disease progressed.

"The mother saw her child as he was today and didn't want to think about what was coming. He needed to be seen by cardiology and nephrology," she says.

Meicke contacted the family and made sure the child was being followed by appropriate specialists. She arranged for durable medical equipment to be available when the need arose.

"We got him a hospital bed early on. This improved his quality of life because he was difficult for his family to lift and the bed allowed him to be more comfortable and safer," she says.

When the child's condition worsened and he needed a wheelchair, it was available quickly because Meicke had the arrangements in place.

At Meicke's suggestion, the family got involved with the local muscular dystrophy association. Through that organization, the child was able to go to a special summer camp for muscular dystrophy patients.

She helped the family find the resources and plans to renovate the bathroom to make it wheelchair-accessible. The sink was lowered so the child could reach it, and the shower was adjusted so the child could be rolled in and shower in his wheelchair.

"It was a very rewarding experience for me and for them as well," Meicke says. ■

hospital setting what the member will need down the road," Bazo says.

She works with the treatment team and the family to make sure discharge planning is carried out in a timely manner and makes sure that the patient's discharge needs are in place.

"All case managers, whether they are in touch by phone or in the hospital, work with the family to make sure they understand the member's condition, the treatment requirements, and the types of services they will need," Bazo says.

Meicke, a case manager for CIGNA, works with the on-site nurse who is handling the member in the hospital. She gets involved by telephone with members to assess what the patients will need when they get home, coordinate care with their physician, and arrange for appropriate post-hospital care.

"My predominant role is follow-through in the long term. It could be very brief or it could be long term when a member has multiple diagnoses or complicated diagnosis and needs quite a bit of intervention," she says. **(For an example of how Meicke handled one complicated case, see story above.)**

When Meicke begins working with a patient with a chronic disease, she makes an assessment that includes how much the patient knows about his or her disease and how much medical care the patient has been getting. She talks with the physician to help identify any treatment goals.

"It's a three-way process. The physician, the patient, and I identify goals and set up a plan that outlines what the patient will do, what I will do, and how we will interact," Meicke says.

She makes sure patients gets the recommended follow-up examinations, know about their diet and medications, and finds out if there are financial problems or other issues that would affect their compliance with the treatment plan.

When a patient seems to be stable, she refers him or her to CIGNA's Well Aware disease management program.

In Arizona, CIGNA has a new program, Treatment Options Support, a nursing line that helps patients choose from options available to them for that disease.

"As an advocate for them, I want to help empower them to take advantage of all the options they have from CIGNA and in the community," Meicke explains.

People with complicated diseases may have needs that go beyond what CIGNA covers or provides — help with transportation, for instance.

Meicke helps them get whatever they need, works with the family and the patient's physician, and follows up for as long as they need care.

Meicke helps them become enrolled in community programs that can help, such as support groups in their neighborhood. While CIGNA wants to encourage people with chronic diseases to move into disease management programs that provide added support and education for those with certain illnesses, the case managers still are available if they need more frequent contact and intervention.

"I am their case manager to assist them, help them heal, prevent recurrence, and help them return to their previous healthy state if possible. If it's not possible, I help them deal with the illness they have and maximize their potential," she says. ■

Future offers CMs opportunities, challenges

Services will be needed more than ever

As the Commission for Case Management Certification (CCMC) celebrates its 10th anniversary this month, leaders in the case management field believe that the demand for case management will continue to grow as the health care system becomes more chaotic and complicated than ever.

"There is an increased need, not just because of the convolutions in the health care system but because there will be more people who are not well served. They will require someone who is not a hands-on provider to guide them through the process and act as their advocate," says **Catherine Mullahy**, RN, BS, CRRN, CCM, of Options Unlimited, in Huntingdon, NY, and a member of the original task force that developed the credential.

Case managers are going to be dealing with an aging and more seriously ill population as the baby boomers grow older and people with catastrophic illnesses or injuries and people with complex care needs survive longer.

In addition, as our country becomes more diverse, the number of people with cultural and language barriers can be expected to increase. These people will need an advocate to help them through the system.

With increasing health care costs and more people who need complex care, case managers will be under pressure to move patients through the continuum quickly and ensure that they get the care they need.

At no time has there been a bigger need for case managers to act as advocates for patients as there is now, says **Patricia McCollom**, MS, RN, CRRN, CMDM, CCM, CLCP, president of Management Consulting and Rehabilitation Service Inc. in Ankeny, IA. She chaired the original steering committee of the National Task Force on Case Management, which concluded that the certification of case managers was necessary. She is past chair of CCMC.

"We have an opportunity to help resolve the problems that exist in health care delivery by putting a well educated, experienced care manager in the center with the patient. We've talked for many years about moving patients into the community quicker and sicker," McCollom says

The nursing shortage will affect case managers in all settings, says **Carrie Ann Engen**, RN, BSN, CCM, president of EnvisionCare Alliance Inc, in Naperville, IL.

Hospitals are facing shortages of care providers and simply do not have time for the patient education and patient monitoring that are necessary for good outcomes, making it more important than ever for case managers to act as patient advocates.

The staffing shortage also may mean that independent case management companies may have problems recruiting personnel because they simply can't compete with the incentives that hospitals can offer, Engen says.

"In the other direction, you can provide better working conditions, better hours, and more flexibility, but we can't keep up with the salaries," she adds.

Along with the shortage of nurses, the health care industry faces a shortage of experienced case managers as well.

"Many of my colleagues who began when case management was in its infancy are now retiring. Case management is not something that a new graduate can do. It requires experience and critical thinking," McCollom adds. Case managers must be experienced health care professionals who have the capability of integrating health care resources and options, she adds.

Case managers in the future will face constant economic pressure to show the value of what they do, from economic value to quality of life, Engen says. They will have to provide more information and documentation as to the value of case management services.

"The problem is that we are not good at measuring outcomes or identifying outcomes from a measurement standpoint. Because case management is

a practice and not a profession, there is a big gap between those who do the research and those who practice," she says.

Educating the public about what case managers do is another challenge, since a very small percentage of people have ever been involved with case management and most have no idea what "case management" means.

The variety of settings in which case management is practicing presents another challenge — designing a credential that embraces all types of case management.

When leaders in the case management field were working on establishing the CCM credential, most case managers were either independent or in the insurance world, recalls **Mindy Owen**, RN, CRN, CCM chair of the ethics committee and a member of the executive board of CCMC.

Now, facility-based case managers are the fastest growing segment of the profession, she says.

Just 10 years ago, disease management and population-based management were practically unheard of, but now they're a part of case management, Owen adds. ■

CM credentials becoming more important than ever

Process helps public understand case manager role

It's disturbing to **Mindy Owen**, RN, CRN, CCM, when she encounters someone who calls him- or herself a case manager but whose job description doesn't sound like case management at all.

"Case management tends to be a buzz word, a title that everybody wants to have. The job descriptions inside case management have become so varied that they don't always reflect case management or the function and skill sets needed for case management," adds Owen, chair of the ethics committee and a member of the executive board of the Commission on Certification of Case Managers (CCMC).

If Owen, an experienced case manager, is puzzled by what some people who call themselves case managers actually do, she wonders how a layperson can ever know whether someone whose title is case manager actually is practicing case management.

Having the certified case manager (CCM) credential can help end some of the confusion, she adds.

"The certification ensures that the individual has a basic knowledge of case management and practices with the understanding of the standards of practice and the code of conduct," Owen says.

Case manager certification can't assure that the individual case manager has more than basic knowledge, it at least provides some way that the public can find case managers who understand and work from the code of conduct and standards of practice, she adds.

Catherine Mullahy, RN, BS, CRRN, CCM, of Options Unlimited, and a member of the original task force that determined a need for a case management credential, agrees.

"Then as now there is, unfortunately, an increasing need for the protection of consumers against what some may purport to do as case management but what in reality is not case management. Case management is a practice that requires so much expertise, knowledge, and experience that it is helpful to have a credentialing certification in place to allow patients and families to level the playing field," she says.

Credentialing offers the public a measure of understand about the case manager's education, experience, and knowledge. It shows the case manager's commitment to continuing his or her education in order to better serve the public, adds **Patricia McCollom**, MS, RN, CRRN, CMDM, CCM, CLCP of Management Consulting and Rehabilitation Service Inc. in Ankeny, IA.

The essence of case management is critical thinking and creativity, since goals may be different from one case to another. There is no cookie-cutter practice. McCollom says.

"There is a huge need for credentialing in the case management field. Nursing has a well-accepted body of knowledge that can be put

COMING IN FUTURE MONTHS

- Managing the care of Alzheimer's patients
- Ways to increase member satisfaction
- How technology can improve your practice
- Documenting case management savings

CE questions

17. According to HEDIS 2000 figures, what percentage of Health Alliance Plan's commercial patients who were hospitalized for mental illness saw a counselor within 30 days of discharge?
A. 32%
B. 59%
C. 92%
D. 98%

18. Buffalo, NY-based Univera Healthcare identifies patients for its depression management program by using lists of its members diagnosed with depression.
A. True
B. False

19. Dawn Velligan, PhD, associate professor at the department of psychiatry at the University of Texas Health Science Center at San Antonio, recommends which of the following methods medication compliance among patients prescribed antipsychotic drugs?
A. Have in-depth discussion with the patients about when they take their medicine, where they keep it, and what kind of reminders they have in place.
B. Give them regular reminder calls to take their medicine.
C. If you see the patient in person, set up pill containers for them and have the patients bring them back to every visit.
D. All of the above

20. When a CIGNA member is hospitalized in the Tampa Bay, FL, area, Joy Bazo, RN, CMC, LHRN, on-site review nurse for CIGNA visits that member within ___ hours of admission.
A. 12
B. 24
C. 48
D. 72

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

together into criteria for entry into practice. It's not the same in case management," adds **Carrie Ann Engen**, RN, BSN, CCM, president of EnvisionCare Alliance Inc., of Naperville, IL.

Case management is a not a profession, it's a specialty practice, she maintains. "It's transdisciplinary in nature and includes social workers, nurses, counselors, psychologists, physical therapists, and occupational therapists, all of whom do case management," Engen says. ■

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. ■

Symptom management gives allergy patients relief

While there is no effective treatment for allergic rhinitis, common allergies that cost $1.2 to $4.5 billion a year in direct medical costs, some patients can take steps to relieve symptoms, according to an evidence report from the Agency for Healthcare Research and Quality (AHRQ).

More than 19 million American workers suffer from allergies to pollen, dust mites, pet dander, and other allergens, suffering symptoms such as sneezing, nasal congestion, headache, poor concentration, and fatigue, the report says.

The report concludes that some patients may find relief with simple steps such as using bedding designed to keep out dust mites or cleaning their homes more often.

Injections to build immunity can reduce or eliminate symptoms for seasonal causes, such as trees and pollens, and year-round causes, such as dust mites and cat dander, the researcher say.

Combination treatment, such as antihistamines plus decongestions or antihistamines plus steroid nasal sprays works better than using any of the medications alone. For more information, see the AHRQ web site at: www.ahrq.gov/clinic/epcsums/rhinworksum.htm. ▼

More health care doesn't mean better health care, report says

Regions of the United States where more health care is delivered don't provide better care than regions with more conservative practice patterns, according to studies by researchers at Dartmouth Medical School and the Veteran Affairs Medical Center in White River Junction, VT.[1]

The studies examined how regional difference in the amount of care received by Medicare patients affected the quality of care and access to care as well as outcomes and patient satisfaction. Researchers examined data on patients hospitalized for hip fractures, colorectal cancer, and acute myocardial infarction.

When they examined regions with nearly identical health care needs, the researchers found that the overall quantity of services could vary by more than 60%. The increased utilization included more frequent physician visits, greater use of specialists, and more inpatient stays.

Patients in the regions with higher intensity of care didn't have any better chances of survival, nor did they express greater levels of satisfaction, the researchers say.

Researchers found that performing more medical service didn't improve any of the measures. In fact, on some measures, such as access to preventive care, high-intensity regions fared worse.

"People assume that more medical care means better medical care. What this study shows us is that a large fraction — perhaps a third — of medical care is devoted to services that do not necessarily improve health outcomes or the quality of care," says **Elliott Fisher**, MD, MPH, co-director of the outcomes group at the Veterans Affairs Medical Center and a professor of medicine at Dartmouth Medical School.

Most of the regional differences were due to the greater number of medical specialists and

hospital beds in higher intensity of regions, Fisher says, adding "We should focus on rewarding health care systems for providing better care, not more or less care."

Reference

1. Fisher E, Wennberg D, Stukel T, et al. The implication of regional variations in Medicare spending. *Ann Int Med* 2003; 138:237-287. ▼

Anxiety poorly managed in hospitalized patients

Anxiety often is poorly managed in patients recovering from a heart attack, new research reports.[1]

While medical records revealed that nearly 75% of patients in the study had received some sort of treatment for anxiety, symptoms of anxiety were documented on less than half of the patient charts.

"Some people were treated for anxiety even though there was nothing in their charts to suggest they were anxious to begin with," says **Susan Frazier**, RN, PhD, lead author of the study and associate professor of nursing at Ohio State University.

In the study, patients recovering from a heart attack answered a series of open-ended statement that helped researchers determine how calm, anxious, tense, satisfied, or worried they felt.

They were categorized into four groups based on their scores.

Nearly half of the patients who rated themselves as feeling extremely anxious had not been assessed for anxiety at the hospital. Slightly less than a third of patients who reported no anxiety had been evaluated for anxiety by a clinician.

The charts showed that nearly three-fourths of the participants received treatment for anxiety, but anxiety had been assessed by a clinician only 45% of the time.

"The lack of congruence between how anxious a patient says he feels, his caregiver's evaluation of that anxiety, and the use of appropriate anxiety management strategies suggest that anxiety management is inconsistent and potentially ineffective," Frazier says.

Reference

1. Frazier S, et al. Management of anxiety after an acute myocardial infarction. *Heart Lung* 2002; 31:399-410. ▼

Bronchiolitis commonly treated with ineffective medicines

Physicians commonly use a wide array of medications to treat bronchiolitis, a common lower-respiratory tract disease among infants and toddlers, but there is no compelling evidence to support these treatments, according to a new evidence report sponsored by the Agency for Healthcare Research and Quality.

Common symptoms of the disease include runny nose, rapid or noisy breathing, wheezing, cough, and fever. The disease is typically treated with inhaled, oral, or intravenous corticosteroids, inhaled epinephrine, and neubulized bronchiodilators because they are inexpensive and generally considered to be safe.

Researchers found no evidence that these medications are effective and cautioned doctors to be cautious about using inhaled budesonide and alpha-2-inteferon because of adverse events found in previous research. Effectiveness of other treatment will not be known until clinical trials are conducted, the researcher says.

The researchers did find support for use of palivizumab as a preventive medicine to protect high-risk infants and children with bronchopulmonary dysplasia, a chronic lung disease, or those who were born prematurely and are younger than 6 months of age.

For more information, visit the web site www.ahrq.gov/clinic/epcsums/broncsum/htm. ■

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