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INSIDE

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Managed care/disease management

Nutrition programs improve health

They also deliver results for pennies a day

The verdict is in. The adage is true: Your patients are what they eat. Studies now prove that well-nourished chronically ill patients are better equipped to manage all aspects of their conditions. Health plans not yet incorporating routine nutrition screening and intervention in their disease management initiatives should bear in mind that these low-cost services have a proven track record of reducing medical costs and improving overall health in the chronically ill and the elderly.

If you doubt the necessity and potential benefit of making nutrition screening and intervention routine health care practice for the chronically ill, consider these findings from recent studies:

- More than 80% of elderly Americans have one or more chronic conditions known to benefit from nutrition intervention.[1]
- Medical nutrition therapy for hypertension resulted in an estimated cost savings of roughly $4,075 per case through a reduction in drug use and the prevention of drug-related complications such as stroke.[2]
- Elderly patients with diabetes and/or cardiovascular disease who use the services of a dietician decreased the frequency of their physician visits and their use of hospital services.[2]
- Hospital costs for patients at nutritional risk were $12,683, or four times greater than the $2,968 price tag for patients who were well nourished.[3]
- The consistent and appropriate use of medical foods for hospitalized patients prevented complications in the treatment of the critically ill and injured. The routine provision of medical foods, or nutritional supplements, could save an estimated $1.3 billion in health care spending in a seven-year period.[4]
- A routine nutrition screening and intervention program of all Medicare members at one independent practice association cost only 21 cents per member per month and resulted in a post-intervention decrease in the number of claims, claim dollars, and emergency department visits

in its Medicare members that resulted in an overall 538% return on its investment.[5]

"People with suboptimal nutrition status, particularly the elderly, run a greater risk of falls, disease exacerbation or, at the very least, have compromised immune systems that cause them to get sick more quickly," says **Janis M. Verderose**, RD, MS, CDN, ACCA, manager of clinical outcomes for Prime Care 2000, a large medical practice group in Albany, NY. "Malnourished chronically ill patients often succumb to their disease or develop co-morbidities that better nourished patients are able to fight."

As easy as ABC

Assessing your patient's nutrition status is simple. The Nutrition Screening Initiative (NSI) in Washington, DC, developed the DETERMINE checklist, a simple screening tool, that can be used by consumers, case managers, or providers to evaluate nutrition risk. **(For other articles on the NSI, see *Case Management Advisor,* December 1995, pp. 161-166, and November 1996, pp. 156-158. The DETERMINE checklist is inserted in this issue.)**

"When providers first look at the DETERMINE checklist, the language is so simple their first reaction is, "Oh, I won't learn anything valuable from this.' But to reach your patients and get them to understand what you are asking, the language must be simple," notes **Jane V. White**, PhD, RD, LDN. White is a professor in the department of family medicine at the graduate school of the school of medicine at the University of Tennessee in Knoxville and president-elect of the American Dietetic Association in Chicago.

The DETERMINE checklist has proven not only to be an effective initial screen of nutrition risk, but also an excellent indicator of chronic depression, White says. "Depression has a big impact on nutrition status and chronic disease. Often, people who score high on the checklist have multiple problems."

The DETERMINE checklist is now incorporated into roughly 60 health plans, says **David A. Smith**, MPP, director of NSI. "So many chronic diseases are directly related to nutrition status — diabetes, high blood pressure, cardiac disease — that assessing nutrition status in patients, especially elderly and / or chronically ill patients, should be an institutionalized part of health care in this country. NSI wants providers to look at the chronically ill and see the whole person, not just the disease. In other words, don't focus on sodium alone when you counsel congestive heart failure [CHF] patients about diet." (NSI has developed a nutrition care manual for chronic disease. The manual provides disease-specific nutrition protocols. **For ordering information, see box, p. 103.**)

In addition, many chronic conditions respond well to nutrition intervention alone. "Diabetes is an obvious example," says Verderose. "Nutrition intervention can go along with pharmacological intervention or be given a trial as the first step. For example, why not recommend a controlled diet for coronary artery disease before writing a prescription for a lipid-lowering drug? Nutrition intervention is less expensive and often provides greater quality of life."

If you're not ready to add a screening tool to your arsenal, White says, be sure to ask providers to measure the height and weight of your patients a minimum of every five years. "We measure the height and weight of young children every time they come into a pediatrician's office, yet too many providers forget to take routine measurements of height and weight for adults," she says.

"A decline in height is an early symptom of osteoporosis, but too many providers simply ask patients their height without taking a measurement. Involuntary weight change can be an ominous sign of impending problems from cancer and heart disease to depression and poor oral health," she explains. "And, by simply improving our patients' diets, we can intervene early and prevent serious complications."

Even bedridden patients should be routinely weighed and measured, adds **Albert Barrocas**, MD, FACS, a general surgeon and medical director of nutrition support and home health services

COMING IN FUTURE MONTHS

- Mentor program boosts compliance in transplant patients
- Why one company says vaccination can actually cure, not just prevent, serious illness
- New Alzheimer's guidelines help physicians manage dementia
- How to prepare yourself for the litigation process
- Integrating complementary therapies into treatment plans

Resources

These groups offer a wide range of free or low-cost professional and consumer resources on nutrition:

• **The Nutrition Screening Initiative**, 1010 Wisconsin Ave., Suite 800, Washington, DC 20007. Telephone: (202) 625-1662. Fax: (202) 338-2334.

• **The Nutrition Institute of Louisiana**, 5620 Read Blvd., New Orleans, LA 70127. Telephone: (504) 244-5078. The institute has a consumer brochure and poster set that helps professionals teach patients the basics of good nutrition, including tips for interpreting the food pyramid.

• **The American Dietetic Association**, 216 W. Jackson Blvd., Suite 800, Chicago, IL 60606. Telephone: (312) 899-0040. Or call the ADA's National Center for Nutrition at (800) 366-8114. The ADA also is completing an education module on dietary supplements, including herbal supplements, due out in early fall.

at Pendleton Memorial Methodist Hospital in New Orleans. "We must start looking at height and weight as routine vital signs, just as we do blood pressure and temperature. You wouldn't let your patients walk in and tell you their blood pressure based on a reading now five years old. You wouldn't simply ask patients what their temperature is today. You shouldn't do that with their height and weight."

Barrocas screens every new surgical patient using the DETERMINE checklist. "The receptionist helps patients fill it out. If there are any positive findings, my LPN addresses them or brings them to my attention. I don't know of any condition or disease where starvation is a recommended therapeutic modality. If my patients are malnourished, I want it taken care of before surgery." In addition, nurses ask all patients admitted to Pendleton Memorial several questions related to nutrition status as part of their admission intake, he notes.

The relationship between chronic disease and nutrition is symbiotic, Barrocas says. "Poor nutrition may contribute to the disease or perhaps the disease interferes with appropriate nutrition. Nutrition is the basis of all physiologic and structural functions of the body, and it also plays a role in the pathology. Nutrition, put simply, can either cause or contribute to chronic disease but must always be considered."

Even healthy patients can be at nutrition risk, White notes. "Women who are running or exercising vigorously without adequate calcium intake, or who have a low percentage of body fat which alters their estrogen production, run a high risk of developing osteoporosis early in life. By routinely measuring height and weight, providers can catch changes in height early enough to intervene before these women develop vertebral fractures."

White says case managers may catch early signs of malnutrition simply by looking at routine laboratory reports with new eyes. "You are already receiving useful information about nutrition from the routine screens taken to monitor chronic conditions, but you simply may not be thinking of the data in terms of nutrition risk," she says.

For example, one of the most sensitive indicators of initial nutrition status in an ambulatory population is serum albumin level. "A serum albumin level of less than three is associated with poor outcomes for a number of diseases, including pneumonia, CHF, failure to thrive, and chronic obstructive pulmonary disease," White explains. "I think it's important as providers and case managers look at blood pressure, blood sugars, and lipids to remember that these are as much an indicator of nutrition status as of disease state. And, also remember that poor nutrition definitely could adversely affect the disease state being monitored."

Move to the head of the class

Health plans that add nutrition to their disease management initiatives also may improve their scores on managed care report cards and accreditation surveys. The Health Plan Employer Data and Information Set (HEDIS) and the National Committee for Quality Assurance (NCQA) in Washington, DC, do not yet have specific performance measures for nutrition care and screening; however, the standards do include implications for nutrition. For example, NCQA and the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, require health plans to demonstrate the delivery of preventive health services, an area where nutrition clearly plays a significant role. **(See box, p. 104, for a recent statement from NSI to NCQA about proposed changes to HEDIS 2000.)**

Also consider that the simplest interventions sometimes are the most effective. "When a

Group criticizes HEDIS for omitting nutrition

The Nutrition Screening Initiative (NSI) in Washington, DC, recently responded to proposed changes to the Washington-based National Committee for Quality Assurance's (NCQA) Health Plan Employer Data Set (HEDIS). In its written response, NSI applauded NCQA's addition of specific measures for diabetes and high blood pressure but criticized HEDIS 2000 for its lack of specific nutrition parameters. NSI wrote:

"It is clear that NCQA is concerned about controlling these and other chronic conditions. However, by omitting specific nutrition parameters from HEDIS, NCQA has missed an opportunity to give health plans the incentive to use the most cost effective and least invasive therapies available. Furthermore, this omission could unwittingly increase pharmacological interventions, driving up health care costs and denying patients the opportunity to manage chronic conditions with the highest quality therapies.

"Nutrition interventions — particularly in the areas of diabetes and blood pressure — have been held to scientific rigor; they are researched, peer reviewed and published. The data on the efficacy of disease-specific nutrition care and geriatric nutrition screening and interventions are extensive." ■

patient walks in with a complaint, nutrition is not the thing that providers consider. Sometimes we neglect the simple things that can have a big impact on health outcomes," says White.

Barrocas agrees that case managers and providers should make a habit of asking patients about their nutritional status. "If you don't care to use the DETERMINE checklist, at least ask several questions directly related to nutrition." He suggests asking these questions:

- Who last asked you about your nutrition?
- Who does the shopping and cooking at your house?
- How many medications are you taking?
- Are you taking your medications as prescribed?
- Are you taking any medications that have not been prescribed by a physician?
- What do you normally eat each day?
- What dietary supplements are you taking?

"Dietary supplements often interfere with the absorption of food and prescription medicines, yet few health care professionals ask patients questions about supplements," notes Barrocas. "Two-thirds of patients try integrative therapies without telling their physicians. Don't leave out questions about vitamins and herbal supplements."

(For guidelines on discussing complementary therapies with your patients, see story, below. For additional information on herbal supplements, see *Case Management Advisor,* May 1999, pp. 69-73.)

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AMA: Know patients' alternative therapy use

More managed care organizations each year add complementary and alternative therapies to their covered benefits. However, many case managers and providers still are unclear how to integrate these often unproven therapies with more conventional treatment for chronic illness.

The Council on Scientific Affairs of the American Medical Association in Chicago released the following recommendations regarding the use of herbal supplements and other alternative and complementary therapies in 1997:

- Routinely question patients about the use of alternative or unconventional therapies.
- Educate yourself and your patients about the state of scientific knowledge with regard to alternative therapies that may be used or contemplated.
- Courses offered by medical schools on alternative medicine should present the scientific view of unconventional theories, treatments, and

practice, as well as therapeutic utility, safety, and efficacy of these modalities.

• Patients who choose alternative therapies should be educated about the hazards that might result from postponing or stopping conventional medical treatment.

Albert Barrocas, MD, FACS, medical director of nutrition support and home health services at Pendleton Memorial Methodist Hospital in New Orleans agrees that case managers always should question patients about their use of herbal supplements as well as other alternative and complementary therapies. He suggests case managers take the following approach to those therapies:

• Keep an open mind.

• Encourage acceptable controlled studies of the therapies.

• Do not ignore or ridicule the potential placebo effect of these therapies.

• Do not accept all new therapies as efficacious.

• Avoid arrogant attitudes toward alternative and complementary therapies and providers.

"Growing up in Cuba, there were many times when home remedies were used instead of or in combination with medications prescribed by doctors," says Barrocas. "I had one young woman with breast cancer. After a radical mastectomy and several months of chemotherapy, distant metastasis became evident and additional chemotherapy offered little hope. She asked me about alternative therapies available. I didn't have any knowledge about these therapies."

Don't forget the power of prayer

Barrocas offered his patient this advice:

• Find out as much as you can about the therapy.

• Get assurances that the complementary therapy provider will give the medical team timely reports and stop the therapy if no benefits are detected by the patient or the provider.

• Continue your chemotherapy and other conventional therapies until the medical team indicates there is no further benefit or when the ratio of risk to benefit becomes prohibitive.

• Pray and do not give up hope.

"During the next year, the patient and her parents became very close to our practice," notes Barrocas. "Neither traditional therapy nor complementary therapies were successful. When she died, we were all saddened but also satisfied that she had been in control of her decisions all along."

(For more details, see the report of the Council on Scientific Affairs. AMA House of Delegates 1997 Annual Meeting. Council on Scientific Affairs Report. *1997; 12-A:1-20. See also: Barrocas A. Complementary and alternative medicine: Friend, foe, or OWA?* J American Dietetic Association *1997; 97:1,371-1,376.)* ■

Use these tips to develop effective DM programs

Here's what you need to do it right

The term *disease management* has been part of the American health care vocabulary for nearly a decade, but how it is defined varies widely from one organization to the next. Your organization may have jumped on the disease management bandwagon in the early '90s without clearly defining the meaning or the scope of this managed care concept.

Disease management experts say it's not too late to go back to square one, assess how you define and develop disease management initiatives, and correct any missteps, if necessary. Writing a concise working definition of disease management is the first step.

"Your definition of disease management should reflect the focus of your organization or business," notes **John C. McDonald**, RN, MS, CPHQ, administrator for general medicine and adult primary care at Vanderbilt University Medical Center in Nashville, TN. "An acute care facility may have one definition and a health plan may have another."

Many organizations focus on one service or product, such as case management or health education, when they define and implement disease management programs, but Vanderbilt uses a more comprehensive definition, adds **Laurel Fuqua**, RN, MSN, administrator of the Gastrointestinal Liver and Nutrition Care Center and director of disease management at Vanderbilt.

"We are trying to evolve all of our disease management programming around a more comprehensive definition. We define disease management as proactive intervention in the identification, management, and treatment of disease so as to organize services and products to address the total care of the patient and reduce costs," she says.

The key to Vanderbilt's definition is a focus on "population management," adds McDonald. "Your focus has to be to keep your population as healthy as possible. If you are healthy, let's work to keep you healthy. If you have a disease, let's keep you as healthy as possible by decreasing complications associated with that disease."

Easy answers can be hard to find. "You can't just say, 'We have a lot of asthmatics. Let's manage asthma.' What will you do with the asthmatic who is also diabetic?" asks **Peggy Pardoe**, RN, BSN, CCM, CPHQ, product development analyst for University Care, the managed care program at the University of Maryland Medical Center in Baltimore. "You have to understand the population you manage, not just the illness. Are your patients from a particular employer group? What does that employer do? Does the employer have specific population-based challenges? Are your patients white, middle-class suburbanites, or black and Hispanic inner-city residents, or a combination of both?"

Pardoe notes that it's also important to understand the popular medical culture of your patients. "Have a clear understanding of the current best practices for diabetes. Then look at how your patients currently manage their diabetes. You have to understand what people are doing and why they are doing it so that you can address those issues in your disease management programs."

DM = good clinical care

Another key part of an effective disease management programs is a "patient-centric" approach, says **Sanjaya Kumar**, MD, MSc, MPH, clinical project specialist with the Baton Rouge-based Louisiana Health Care Review, a peer review organization contracted by the Health Care Financing Administration in Baltimore to improve quality of care for Medicare recipients in Louisiana. "The individual patient, not the disease process or cost containment, must be the focal point of all attention in terms of interventions that will be carried out in your disease management programs," he says.

"I see disease management as the provision of coordinated, comprehensive care via a multidisciplinary team across the continuum of care to achieve improvement in identified outcomes, such as functional status, quality of life, and medical costs," Kumar explains. "Disease management is no more than good clinical care across the continuum, if that is feasible under the current American health care system."

Whether you're sitting down to refine your definition of disease management or starting from scratch, you can't just write it down and then set it aside, Pardoe cautions. "You have to develop a definition that everyone in your organization agrees with. You can't have renegades," she says. "You must have a party line. That party line is going to drive every disease management program you develop. It's the philosophy that determines everything else you do."

Assess readiness for DM

Your definition of disease management forms the framework of the programs you create, she notes. "Does your organization think of disease management as pharmacy management? Do you look at disease management as health education? Do you separate disease management in your mind from case management? Or do you want to meet all the needs of the patient with a comprehensive approach that includes all of those services and more?"

Fuqua and McDonald suggest asking the following questions to assess your organization's readiness to develop and manage its own disease management programs:

- What are your partnering capabilities and philosophies?
- How cost conscious are your employees?
- What are your quality efforts, and how effective are they?
- What data collection and monitoring capabilities do you have?
- What are your network relationships?
- What are your supplier relationships?
- What is your financial exposure or risk?

"These are key questions to answer to determine your readiness to take on the development of effective disease management," Fuqua says. "The answers to these questions will help you decide whether you should build your own programs or outsource. Every organization must answer those questions honestly. Most programs that fail do so because they haven't given enough thought to those questions."

Kumar suggests adding a question to the list. "You must determine the boundaries or scope of your proposed disease management efforts. For example, do you want to intervene with all diabetics, or only those who need specific types of interventions, or only those with extremely high costs." **(See p. 107 for tips on establishing intervention levels for your disease management programs.)**

Homegrown disease management programs often are more valuable than vendor carve-outs because once you have built the infrastructure and developed your disease management philosophy and methodology, you can apply those elements to any future disease management efforts, say Kumar and Pardoe. However, if your organization's infrastructure lacks the necessary elements to conduct effective disease management initiatives, you may consider turning to a vendor. **(See story, p. 108, for components of an effective disease management program.)**

Just remember: If it sounds too good to be true, it is, Kumar says. "If the vendor shows you a dramatic decrease in terms of admission rates for a given population within a short time span, then I can assure you that there's some fallacy built into the data."

Also, don't be swept away by a glossy brochure, adds Pardoe. "Look at the fine print and ask lots of questions."

Pardoe and Kumar suggest asking vendors these questions:

- What studies were done?
- What scientific rigor was used in those studies?
- What was the study design methodology?
- What analytical methodology was used?

"If you don't examine what you are being shown, you may be tempted to jump into a risky arrangement," Kumar cautions.

You may find a vendor can provide specialized services that your organization cannot. However, even when you use a vendor, you must stick to your own definition of disease management and your own strategic goals, Pardoe says. "You develop that definition. From the definition comes the strategic plan for each of your disease management initiatives. You stick to it. If you don't, you will be at the whim of vendors and end up with a disjointed approach to your entire disease management effort."

The key to successful partnerships with vendors is to define the characteristics of your disease management initiatives clearly and make sure the vendor commits to your philosophy, she says.

"You must also establish exactly what you are purchasing and see if it fits that philosophy. Does the vendor offer the services your disease management strategy requires? For example, does the vendor provide case management or just health education? You want to be able to say, 'Whether we are planning an asthma program or a congestive heart failure program, these elements will always be the same.' Vendors can reach a wide variety of patients. They can manage a wide variety of patients. What you have to weigh is whether they can manage your particular patients as well as you can internally," Pardoe explains.

"Do they provide personal education? Do they use case managers to deliver that education? Are those case managers certified? If their nurses aren't certified, it tells me they have nurses but those nurses may not understand how to facilitate and coordinate services," she says.

The same holds true for outcomes. "If you choose a vendor, make sure that the vendor is willing and able to gather the outcomes you need, not the outcomes that make the vendor look good," she says.

Don't be afraid to ask the vendor which software it uses to gather and analyze the data, Pardoe adds. "You may find that the software is commercially available and costs less to buy than the vendor's services." ■

Are all people who have diabetes created equal?

The answer is no, and they require different care

If you keep the "patient" at the center of all your disease management programs, you soon realize that not all interventions are appropriate for every patient in your target group, says **Sanjaya Kumar**, MD, MSc, MPH, clinical project specialist for Louisiana Health Care Review, a peer review organization in Baton Rouge. **(For more advice on developing disease management programs, see p. 105.)**

"Your program should define what action is taken depending on the degree of progression of disease," he explains. "You must select some logical pattern of interventions based on identified characteristics within the group you've captured."

Using diabetes as an example, not all diabetics will have the same degree of knowledge about diabetes management, Kumar says. "One preliminary step you should take is to capture basic information about your population through patient records and billing data. Which diabetics have been hospitalized? Which have been in the

emergency room? Which have experienced foot problems?"

After gathering these preliminary data, you should stratify your population into action groups, he notes. "The interventions should be common to all the diabetics in your population. What will vary is the intensity, or frequency, of the interventions."

"People are not automobiles. Your population is not going to be static."

Assume, he says, that you have a population of 100 diabetics. You decide to place them into three intervention categories. The first group consists of stable diabetics requiring minimal intervention. The second group consists of mildly unstable diabetics requiring a slightly more intense level of intervention. The third group consists of uncontrolled diabetics requiring the highest level of intervention.

"You may have five or six interventions included in your diabetes management program," Kumar says. "The first might be telephonic coordination of services and follow-up by nurse case managers. The second intervention might be education regarding their disease — nutrition and exercise guidelines. What varies is the frequency of the phone calls from the case manager and the number of health education interventions. You may schedule calls once every three months for the stable group and once every two weeks for the uncontrolled group."

Intervention groups change

Yet you also should remember that patients will not necessarily remain in the same intervention group, he says, explaining that your program should include clinical guidelines for reevaluating patients to check their status. Do you, for instance, test hemoglobin every three months for stable patients or every six months?

"People are not automobiles. Your population is not going to be static. It's going to be dynamic," Kumar explains. "Those diabetics who were stable on enrollment may have a death in the family which causes them to neglect themselves and moves them into the uncontrolled category. You may have to increase the frequency of your interventions until they stabilize and then move them back to their original category." ■

Does your DM effort have what it takes?

Experts say you need these four components

If your organization is already committed to developing disease management programs, four essential components are necessary to implement them. If your internal infrastructure lacks any of these components, your disease management programs may be destined for failure:

1. **Leadership.** "You must have buy-in and support from the top down. Organizations who are truly doing disease management are creating a change in philosophy from fee-for-service, episodic care to comprehensive preventive care," says **Laurel Fuqua**, RN, MSN, administrator of the Gastrointestinal Liver and Nutrition Care Center and director of disease management at Vanderbilt University Medical Center in Nashville, TN.

"If you can get your top people to buy into a disease management philosophy, then you can develop programs that are successful in the long term and not just stop-gap measures. Disease management that meets the needs of patients also meets the needs of organizations," says **Peggy Pardoe**, RN, BSN, CCM, CPHQ, product development analyst for University Care, the managed care program at the University of Maryland Medical Center in Baltimore. "But you can't save money without spending money. Disease management programs are costly. You must have support at the top."

You also must have your providers on board, cautions **Sanjaya Kumar**, MD, MSc, MPH, clinical project specialist with the Baton Rouge-based Louisiana Health Care Review, a peer review organization contracted by the Health Care Financing Administration in Baltimore to improve quality of care for Medicare recipients in Louisiana. "Every time you develop a new disease management program, you must allow your providers a period of comment. Let your providers have input. They may add something you've overlooked. And, they are more likely to comply with your protocols."

2. **Disease management mindset.** "You must ask some key questions to help you understand where your organization stands right now, today, in terms of disease management," says Fuqua.

Questions you should answer include:

• What percentage of our daily efforts currently focus on disease prevention?

• What percentage of our services are available in outpatient and other alternative settings?

• To what extent have we carefully evaluated our current efforts at prevention and costs?

"If the answer to any or all of those questions is 0%, then you have a lot of groundwork to do before your disease management programs succeed," notes Fuqua.

3. **Integrated case management.** "Case management is the tool that assures that your standards of care for disease management are translated during the delivery of care," explains **John C. McDonald**, RN, MS, CPHQ, administrator for general medicine and adult primary care at Vanderbilt University Medical Center. "If your disease management protocol calls for certain lab tests to be performed at regular intervals, case management — whether performed by physicians, physician extenders, or nurses — is the tool you use to make sure those tests are performed on schedule."

"You always want case management to be part of your disease management process," agrees Pardoe. "Case managers have a way of establishing a relationship with patients and encouraging them to comply and participate in your programs. To gain compliance, you have to first gain the trust of your patients."

Pardoe recalls a patient who had been labeled "noncompliant" when she was working as a case manager for an asthma management program. After contacting the young woman, Pardoe found out she had been thrown out of her home, and her insurance card was left behind. "I contacted the clinic and begged them to see her even without her card. I looked into her legal options including her eligibility for Medicaid. She was living on the street, staying with friends. She could not have cared less that she wasn't taking her maintenance steroids. Her life was a shambles. You can't ignore those obstacles. That's where case management comes in."

The easiest way for case managers to gain better patient compliance is to simply ask, "What do you need to make it easier for you to manage your disease?" Pardoe notes. "Ask the client to tell you the biggest problem they currently face. Or ask them to tell you the one thing that you could help them do better. You may have a parent with no particular interest in better asthma management for their child. However, that same parent may be missing too many days from work to care for the asthmatic child. Now, you have some common ground to get that parent's buy-in. Tell them you think you know a way to make it possible for them to miss fewer days from work.

"When you develop your disease management programs, you can't ignore the social, cultural, and spiritual aspects of your patients and how those aspects of their life affect their disease and their health," she says. "These are issues that case managers are well-suited to evaluate and address."

Most organizations have some type of case management, notes Kumar. "Find out what is currently being done for patients in your organization. You may find that many of the functions you want to include in your disease management programs, in terms of care received and follow-up after inpatient discharge, may already be taking place," he says. "You must look at your current case management process and see how you can coordinate that process with your disease management efforts." **(See story, p. 110, for details on the prevalence of case management programs in the acute care setting and box, p. 111, for what qualifications hospitals look for in case managers. See also pp. 112-113 for discussion on what education case managers need to work effectively in today's managed care environment.)**

You may need to change some of the operations of the case management department to better support your disease management efforts, Kumar adds. "That's when you realize again the importance of that top down buy-in for your disease management efforts."

4. **Outcomes management capability.** "You have to be able to gather data that shows you've had an impact on patient health." says McDonald. "That requires determining certain indicator points and tracking them. For example, we know that diabetics are less likely to develop chronic complications if their hemoglobin A_{1C} is kept as close as possible 7%."

"You have to figure out which outcomes will help prove the effectiveness of your efforts and then determine what systems you need to measure them," says Pardoe. "You don't have to start out with a sophisticated information system. You can start small and expand as your program expands."

One way to determine your data analysis capabilities is to write a request for proposal (RFP) to

your own organization, Kumar says. "Too many times, the right hand doesn't know what the left hand is doing in large organizations. Have your disease management team perform a needs assessment and then send out an RFP to see what is already available in your own organization. In addition to data analysis, you're going to need analytical support.

"You need to understand and interpret the data once it's gathered. Check to see if your organization has an academic affiliation you can tap into. Publicize your needs. There are hidden people within your organization. Don't reinvent the wheel," he says.

If you are going to the time and expense of gathering data, make sure it's data you can really use, he adds. "Don't collect it if you're not going to use it. Go back to your clinical goals and program parameters. Does the data you plan to gather support them?

"Many of the functions you'll want to perform can be done with readily available business software, like Microsoft Excel. Don't let the need for information systems hold back your disease management efforts," Kumar says.

It's also important to determine a consistent approach to collecting outcomes data for each disease management initiative you develop, Pardoe says. "This will save time and establish a uniform way of reviewing outcomes while comparing the effectiveness of your various disease management programs."

(For more on what it takes to develop effective programs, see cover story.) ■

Professional development

Study finds most hospitals have case management

Managed care presence is not driving force

The speculation is over. Nearly 74% of hospitals in the United States now have case management. Not only that, but the same study shatters the conventional wisdom that case management has been a response to managed care.

A large-scale study of hospital case management in the United States found no significant relationship between case management implementation and the level of managed care penetration in local markets. "This was one of the most surprising findings in terms of prevalence of case management," says the study's author, **Jana Stonestreet**, PhD, RN, chief nursing executive for Methodist Health Care System in San Antonio. "We've said for years that case management is a response to managed care, but the research doesn't support that claim. You could speculate that hospitals are implementing case management due to the anticipated growth of managed care, but it would only be speculation."

Stonestreet mailed questionnaires to the chief nursing executives of 3,648 hospitals nationwide. She used a guide published by the American Hospital Association in Chicago to select general medical/surgical hospitals. "I chose the chief nursing executive as the most likely person to be able to answer questions related to the prevalence of case management in their hospital," she says.

More than 1,100 chief nursing executives returned Stonestreet's survey for a response rate of 32.6%. Of the 1,131 respondents, 73.7% said they had case management as identified by Stonestreet's definition.

Although the study found no relationship between managed care penetration and case management implementation, other factors do appear to have a significant relationship with the prevalence of case management in the acute setting. Those factors are:

- **Bed size.** 49.4% of hospitals with fewer than 50 beds reported having case management, compared with 97.9% for hospitals with 601 or more beds. "It was a stair-step relationship. The more beds the hospitals had, the more likely they were to have case management."
- **Ownership.** 85% of for-profit hospitals reported having case management, compared with 71% of not-for-profit hospitals.

What's up, doc?

Of the 270 hospitals that reported not yet having case management, 57% reported plans to implement case management in the next one to 18 months, with five months as the most frequently cited time frame. "There were 31 hospitals who reported that they had implemented case management but discontinued their programs," says Stonestreet. "The most frequently

cited reason for discontinuing case management was a lack of physician support."

Other reasons cited for discontinuing case management were an inability to continue funding the case management program and inability to recruit qualified case managers.

"About 23% reported that they couldn't find qualified case managers," Stonestreet notes. **(See box, at right, for data on who hospitals hire to do case management.)** She also found that for-profit hospitals case manage a larger percentage of their patients than not-for-profit hospitals do. "I found that on average, nationwide, about 72% of all inpatients are case managed. In about one-third of hospitals, 100% of patients are being case managed," she notes. "That seems to go against the literature, which suggests case management is most effective when organizations target only their highest cost, highest use patients for case management services."

Only 10% of hospitals surveyed reported case managing patients after discharge or in the outpatient setting. "The most frequent response by far was that hospitals case manage none of their patients after discharge," she says.

Second survey targets hospitals with CM

Stonestreet sent a follow-up survey addressed to the directors of case management of hospitals that reported implementing case management. The second survey included 49 questions related to the structure, process, and outcomes associated with case management in hospitals. In total, she mailed 834 questionnaires. A total of 376 surveys were returned for a response rate of 45.1%

Areas covered on the case management director survey include the following:

- What case management structures do you have in place?
- Is case management incorporated with other departments such as social work, or does it stand alone?
- Who does the case manager report to?
- How are case managers assigned to patients?
- How are patients referred for case management?
- What tools do case managers use?
- What processes do case managers use?
- What information systems are used to support case management?
- What outcomes have case managers achieved?

Stonestreet plans to publish the data from the case management director survey in the near future. "When I was planning my dissertation, I found gaps in the literature. Most of the published studies reported the case management experience of individual hospitals. I found few studies that describe what exists today across segments of the population and no studies describing what exists nationwide in acute care case management."

She says she hopes her work will form a foundation for other researchers to build on. "It's as if in case management we skipped a preliminary step in the research. We jumped right to outcomes studies because there was administrative pressure to prove the effectiveness of case management,"

Who's doing CM in hospitals?

The debate continues to rage over who is best qualified to do case management. Must case managers have bachelor's-level preparation? Must case managers seek certification?

Good data now exist on hiring practices for case managers in the acute setting that begin to shed light on those questions. In her recent study of hospital case management in the United States, **Jana Stonestreet**, PhD, RN, chief nursing executive for Methodist Health Care System in San Antonio, TX, found that nearly every hospital in the United States hires RNs as case managers.

Of 374 respondents who answered study questions related to case managers' education and other qualifications:

- 99.1% hire RNs as case managers.
- 55% hire only RNs as case managers.
- 65% hire RNs regardless of degree preparation.
- 38% also sometimes hire social workers and licensed vocational nurses.
- Several hospitals reported sometimes hiring respiratory therapists and/or information systems professionals as case managers.
- Only two hospitals reported requiring case managers to be certified.
- 28% prefer case managers to be certified but don't require it.
- Of certifications mentioned, the Certified Case Manager (CCM) from the Commission for Case Management Certification in Rolling Meadows, IL was preferred by the majority of hospitals surveyed.
- 50% hire case managers with three years or less of clinical experience.
- 83% hire case managers with general clinical experience. ■

she says. "Yet if you scrutinize the studies in the literature, they don't often describe who the case manager is or precisely what the intervention was. They provide little clear description of the roles and responsibilities of the case manager or the tools used to document their outcomes.

"I see my work as a broad overview of the current status of hospital case management," she says. "I think my high response rate indicates that people are very interested in this area of study. Another researcher might take a section of my data and focus in on [his or her] own interests. For example, I asked several questions about information systems used for case management. Another researcher may want take those responses and do a more focused study looking at information systems alone." ■

What preparation do CMs really need?

Here's one educator's tough stance

If you think that bachelor's- or perhaps master's-level preparation isn't necessary for case management professionals, consider this: Would you take your child to a physician with only two years of formal medical education?

"As a profession, nurses and nurse case managers must get beyond the debate over whether they must be bachelor's prepared, if they want to be viewed as professionals," says **Gregory L. Crow**, RN, BSN, EdD, director of the leadership and case management programs for the school of nursing at Sonoma (CA) State University. "Every other professional group in health care has recognized this problem and addressed it. Physical therapists, respiratory therapists, and pharmacists have all addressed the issue of mandatory bachelor's-level preparation for entry into the field. The time has come for nursing to do so as well.

"I'm not saying for one moment that associate-degree nurses aren't good nurses. I started my own career through a diploma program. I am saying that the associate degree is the beginning point of our nursing education, not the end point," says Crow.

"The health care system in this country continues to go through a restructuring process. If we don't have nurses who understand the financial implications of the systems they work with and within, they can't affect change," he notes. "As nurses, we are simply shooting ourselves in the foot if we say education doesn't matter." **(For a quick look at qualifications hospitals look for in case managers, see box, p. 111. For one case manager's view of the marriage between education and accreditation, see p. 113.)**

Sonoma State was the first nursing program in the country to offer an RN-to-BSN program in the early 1970s, Crow says. Since 1995, the university also has offered a distance-learning case management master's program for nurses delivered first via teleconference and now with the addition of Internet access.

Students in the case management master's program are required to take courses in these areas:

- health policy;
- nursing theory;
- professional issues, including legal issues related to advanced nursing practice;
- financial management, including production of a business plan related to case management;
- systems theory;
- case management theory.

"Systems theory is a new requirement for the case management program," Crow says. "I have talked to too many case managers who found themselves plopped down into a system that didn't support case management. The course is designed to help students analyze different health care system models from more than one perspective."

Students are required to take two semesters of case management theory. In the case management theory courses, students follow a patient population, such as congestive heart failure patients, and prepare an analysis based on the case management framework developed by the Case Management Society of America in Little Rock, AR.

"Students follow that population on a micro-level and come out of the first semester with a case study that includes outcomes and cost data relative to that population. They work with a mentor to solve case management problems or implement a case management program for a specific patient population. We encourage students to think broadly," says Crow.

In the second semester of case management theory, master's program students look at the macro-level. "They look at systems of case management across the continuum of health and across the continuum of life — a horizontally and vertically integrated approach," he says. "When they graduate,

they are exhausted. It's a tough program."

The information age we've entered requires case managers to identify data-gathering needs and make fact-based decisions, he explains. "Those are skills I didn't get from either my diploma program or my baccalaureate program. Those advanced skills go beyond knowing research and move into why and what and how to analyze data. There just isn't time to develop those skills properly in most baccalaureate programs."

(*Case Management Advisor* has been following the debate over case management education and certification needs. **See the following *CMA* articles for more discussion: January 1997, pp. 1-6; November 1997, pp. 191-195; December 1997, pp. 201-205; January 1998, pp. 1-8; March 1998, pp. 42-47; April 1998, pp. 57-60; December 1998, salary survey supplement.**) ■

Don't overlook need for certification

Learn to blend education and experience

Formal education, such as bachelor's- and master's-level preparation, is becoming increasingly important for case managers in today's competitive environment. However, one nurse executive cautions that education alone is not the solution. Qualified case managers, she says, must have a blend of education, clinical experience and certification.

"We need to marry the experience with the theory and not allow one to carry more weight than the other," explains **Peggy Pardoe**, RN, BSN, CCM, CPHQ, product development analyst for University Care with the University of Maryland Medical Center in Baltimore. "I think that bachelor's-level preparation is important. I think we sometimes promote people with years of experience to take on roles that they may not be qualified to perform."

System's theory such as that learned in bachelor's- and master's-level course work is vitally important in today's environment, but so is real world experience, Pardoe says. "Many instructors teaching graduate-level theory for case management have never been case managers. There seems to be a disconnect between the experience that case managers bring to their role and the individuals who have the skills to teach them to go beyond that experience." (System's theory is now taught regularly in bachelor's- and master's-level case management courses. **See article on components of master's-level case management education, p. 112.**)

For Pardoe, the most important initials for case managers to have after their name are not BSN or MSN, but CCM, for certified case manager. "Certification is the marriage of experience and theory. The commitment a case manager shows by becoming certified says to the world that this case manager is willing to be held accountable to a higher standard."

The main reason case managers should strive to earn the CCM is that it shows that they have a clear understanding of the basic tenets of case management, she says. "If I'm evaluating the disease management program of a vendor, I want to know that the nurses who implement the vendor's programs are case managers, not just RNs. If they are RNs, or even advanced practice nurses, it tells me they may know a lot about that particular disease, but without that 'CCM' I'm not convinced they can effectively manage my patient population." **(For more on selecting a disease management vendor, see p. 105.)** ■

Workers' comp/disability management

Qualified contractors save money, heartache

Certificate program helps CMs find them

A 47-year-old man lost his leg due to a work-related accident at age 34. His remaining leg was shattered, leaving him with a full leg cast for nearly three years. His home was modified by a contractor for wheelchair access. The contractor hired by the workers' compensation company to complete the home renovations underbid the job and had to return to the insurance company for more money.

Not only did the work not come in for the originally quoted cost, but the modifications were done improperly. The insurance company later had to ask a more qualified contractor to tear

down the original work and reconstruct the home modifications. The insurance company paid twice for a single environmental modification project for a total cost of nearly $85,000.

"This is a familiar story," says **Jim Karl**, BS, GC, CEAC, owner of All In One, an environmental access contracting company in Woodstock, GA. "A typical contractor comes in and says, 'Yeah, I can widen that doorway.' But he doesn't understand the significance. He doesn't know how the wheelchair works and turns on the floor. He's focused on the doorway, but he's clueless to all the issues. For example, he may have the door opening into the bathroom when there's more floor space, and therefore more room to maneuver the wheelchair, if the door opens into the bedroom."

Karl has two workers' compensation "redo" jobs. "We're going back and tearing out the original work and doing it right at a cost of $20,000 to $50,000," he says. "What case managers and consumers should realize is that if an environmental access contractor bids the job originally, it may come in for about $3,500 to $5,000 more than a general contractor's bid. Every item a qualified environmental access contractor suggests may add 5% to the total cost. However, if that's what it takes to have the job done right, it's still a lot less than $20,000 to $50,000 to have it redone later."

From certificate to certification

Two case managers' frustration over the shortage of qualified and ethical contractors for their clients' environmental access needs caused them to spend more than five years developing the certificate in environmental access contracting (CEAC) program. "It took us five years through study groups. It has been a slow, precise process, and now we've formed a board to take the steps necessary to move the certificate program to a true certification," says **Kathleen Moreo**, RNCm, BSN, BPSHA, CCM, CDMS, CEAC, owner of PRIME, a case management education and consulting company in Miramar, FL, and president of the Case Management Society of America in Little Rock, AR.

To qualify for the certificate program, contractors must have a minimum of two years of experience in environmental access work. "I told myself it was waste of time to go down and go through the certificate program. I had been doing medical remodeling for more than 15 years," notes Karl. "But what the program does is raise the professional standard of what we do and give the consumer confidence that they are hiring the right contractor for the job. The CEAC has guidelines, by-laws, and a code of ethics that contractors must follow. If you breach the code of ethics or fail to follow certain guidelines, the board will sanction you and take away your CEAC."

The certificate program is demanding. "I had already done this type of work for years, but I didn't breeze through the 100-question exam with a score of 100. I learned a lot," he says. "Case managers who hire a CEAC contractor can read the report with confidence and be assured that when the job is done, no one will have to come back in." **(See story, p. 115, for elements of a medical remodeling assessment.)**

"The CEAC contractor is also someone who knows how work with a health care team," he adds. "Take a client on a respirator. I know I have to work with the respiratory therapist. The dust I'm creating during the remodeling process may be a major health impediment for the client. The client may have to move out for a period during the construction project."

Medical remodeling is a growth industry, adds Moreo. "It's not just the disabled who need home modifications. The population is aging, and many clients want to age in place. Their homes are paid in full, and simple adaptations make it possible to stay safely in their homes as they age."

Of course, case managers know that many home modifications are not covered by insurance benefits. "It's up to case managers to tell families that this option, home remodeling to allow disabled or elderly clients to stay in the home, is available. You simply must inform them that the resources are there and suggest they consider using them." Moreo says.

"Our responsibility as case managers is to address needs whether they are covered or not," agrees **Anne Llewellyn**, RNC, BPSHSA, CRRN, CCM, CEAC, owner of PRIME. "Let the family know that this is an issue they should be informed about. The case manager should also document that the client and the family were notified about remodeling options. That two environmental access specialists in the area were identified and recommendations made. This is simply what it means to be a holistic, turnkey case manager."

The CEAC program also offers case managers an opportunity to move into the rapidly growing medical remodeling market. "Medical remodeling was recently identified by a business publication as one of the 20 hottest career moves for

working women. People want to age in place. We can't warehouse the elderly any longer. There's not enough room, and psychologically it's much better for older clients to age in place than to be placed in nursing homes," says Moreo. "The need for environmental access is going to come to everyone at some time. It's a health and wellness issue. Case managers who can evaluate medical remodeling needs and make recommendations have an added skill. They become valuable resources to meet a wider range of their clients' needs."

(For additional information on finding a qualified accessibility contractor, see stories below and in *Case Management Advisor,* February 1999, p. 31.) ■

How to find a medical remodeling contractor

Make sure your clients' needs are met

Accessible Housing, a national network of environmental access and medical remodeling contractors in Miramar, FL, uses an environmental evaluation tool to assess the client's relationship to environmental functions and the need for environmental modifications.

The tool evaluates:

- the client's abilities and disabilities based on aids to daily living;
- objective and subjective data obtained from the client, the client's family, and members of the care management team;
- statistically hazardous areas based on physical or mental impairments;
- care management needs as they relate to delivering services and products to the individual;
- necessary assistive devices and medical equipment;
- use of diagnosis-related adaptation tools for improved architectural access.

Accessible Housing provides a free referral service to help case managers locate medical remodeling contractors who have received distance or on-site training in home modifications and environmental access. For details about the referral service, call (888) 431-7267.

Case managers also may want to request information about accessible code compliance and other environmental access issues from the Fair Housing Information Clearing House in McLean, VA. Most publications are free or available at a minimal cost. Contact the Fair Housing Information Clearinghouse, P.O. Box 9146, McLean, VA 22101 or call (800) 343-3442.

Another potential source of qualified medical remodeling contractors is the Medicaid waiver program in your state. "Many state Medicaid programs now fund environmental access remodeling," says **Kathleen Moreo**, RNCm, BSN, BPSHA, CCM, CDMS, CEAC, owner of PRIME, a case management education and consulting company in Miramar, FL, and president of the Case Management Society of America in Little Rock, AR.

"Simply call the Medicaid waiver program and ask them who is doing the work for them in your area. Even if your client doesn't qualify for Medicaid, you can use the program's medical remodeling provider and have some assurance that you are selecting a qualified contractor."

In addition, you may contact the CEAC (certificate in environmental access contracting) administrative office at (954) 436-6300 to locate a CEAC contractor in your area or for more information about the certificate program. ■

Behavioral health

CIGNA turns to mental health carve-out

CM approach quickly resolves claims

Mental illness is the primary diagnosis in roughly 20% and the secondary diagnosis in up to 65% of all disability claims. Although the literature suggests that returning employees on mental disability to an active lifestyle and their working environment shortens the length of disability, many payers and employers alike are reluctant to encourage early returns to work.

"No one wants to touch a mental disability claim. Employers are uncomfortable with mental illness. They unsure how the employee will react in any given situation, and claimants stay out on disability for much longer than necessary in many cases," says **Kenneth Millsap**, BS, PTA, assistant vice president of loss containment for CIGNA Group Insurance in Philadelphia. "And we can't

expect all case managers to have a good handle on managing mental disability claims. These cases require nurses and psychologists with significant psychiatric experience."

CIGNA has turned to its sister company, MCC Behavioral Care in Minneapolis, to manage its mental disability cases aggressively and return claimants to the workplace. "When we get a mental disability file, our nurses look for certain parameters which may suggest that the claim is not being appropriately handled. If the file raises any red flags, we refer the case to MCC," says Millsap.

Goal: Return quickly to work

Some examples of cases recently referred to MCC include:

- files open for six months or longer;
- files with no clear treatment plan;
- files that indicate the claimant sees psychiatrist once a month for prescription renewal with no other therapy documented.

"We are trying to identify mental health claims at the earliest possible stage to start an appropriate treatment plan and get the claimant back to work," Millsap explains. **(See stories on returning employees to the workplace and common myths about mental disability claims, p. 117.)**

The referral program does help return claimants to the workplace earlier. In 1997, CIGNA conducted a pilot of the MCC referral program with several customers who had a high incidence of mental health disability claims with overwhelmingly positive results. Those include:

- 35% of the 250 claimants were determined to be ready to return to work full time.
- 38% of the claimants were placed in vocational rehabilitation or transitional work arrangements, with the goal of returning them to full- or part-time work.
- Average duration of mental health disability claims decreased by 15%.

Before CIGNA refers mental disability claims to MCC, CIGNA nurses collect all the available medical documentation from the attending physician. "We want the MCC psychologists to have a clear picture of where the claim stands and what's been happening with the claimant to date," explains Millsap.

An MCC case manager, either a psychiatric nurse or a social worker/psychologist, contacts the claimant by telephone and conducts an interview to further clarify the status of the disability and the claim. Questions the case managers asks include the following:

- Are you in treatment at this time?
- What type of treatment have you received or are you now receiving?
- How has the treatment worked for you?
- What medication are you taking?
- How often do you take your prescription?
- Are you able to perform daily tasks?
- Do you participate in any recreational activities?

"Case managers gather the information from the claimant to identify any other red flags before contacting the attending physician for more information," Millsap says.

After interviewing the physician and documenting all findings, the case manager refers any questionable claims to a MCC psychiatrist for review. "The psychiatrist reviews the chart and then contacts the attending physician or psychologist for a peer-to-peer consultation," he says. "The MCC psychiatrist gives the attending provider feedback and makes recommendations for resolving the claim and returning the claimant to the workplace. They only make recommendations. Disability claimants have the right to receive any treatment they want, but we've found that the attending providers are very open to this type of peer-to-peer exchange."

After the case review . . .

Providers are more receptive to recommendations from the MCC psychiatrist than to recommendations made by case managers, Millsap says. "We're finding we get much better results from peer-to-peer communication. The psychiatrist speaks to the attending provider as a colleague. The psychiatrist says, 'We've found these services or treatment very effective. Perhaps you should consider them for your patient.' If it's simply information about a new medication, providers listen to case managers. However, if you're suggesting an entirely new treatment plan, it's more acceptable from a peer."

After the case review is complete, MCC provides the CIGNA Group disability case manager with a comprehensive summary of current clinical, psychosocial, and occupational factors impacting the duration and outcome of the employee's disability. This summary provides the information CIGNA needs to make a benefits decision. ■

Unaddressed issues may complicate return to work

At the root of a mental disability claim, case managers often uncover workplace issues that have been unaddressed by the employee's provider. By addressing the human resource issues that delay or prevent the employee's return to work, the claim often can be resolved.

"Sometimes, the depression or nervous disorder is actually caused by a problem at work," notes **Kenneth Millsap**, BS, PTA, assistant vice president of loss containment for CIGNA Group Insurance in Philadelphia. "The employer is often unaware of the issue. Treating physicians also often fail to address issues at work with the employee. So the employee stays out on disability, and the work issues preventing the employee's return to full productivity are not resolved. It's not just that the employee has a fear of returning to the workplace, but the human resource department often doesn't want the employee back until he or she has been completely released by his or her psychiatrist," he adds.

Finding motivation

CIGNA refers its unresolved mental disability cases to its sister company MCC Behavioral Care in Minneapolis. Psychiatric case managers interview employees to determine whether there are any personal or professional issues preventing their return to work, says Millsap. **(See story on MCC's case management approach, at right.)**

He recalls the case of a 37-year-old woman who worked as a quality assurance specialist for a large manufacturing company. She was diagnosed with major depressive disorder and adjustment disorder and placed on disability. Her psychologist noted that her initial symptoms included an inability to think, sleep, or function in her usual activities. The employee reported feeling overwhelmed and unable to cope with major stresses in her personal life. The symptoms were still present three months later when the woman was under a psychiatrist's care for medical management.

CIGNA referred the case to MCC six months after the disability onset. An MCC case manager contacted the woman and her psychiatrist. The woman told her MCC case manager that she was fully able to perform daily activities, enjoyed recreational activities, and was currently representing herself in a legal matter.

An MCC physician advisor reviewed her case and discovered when talking to her attending psychiatrist that a work site issue, not the claimant's medical status, was the major barrier to her returning to work. MCC found no evidence of disability and recommended the employer address the human resource issue that was affecting the woman's motivation to return to work. The employer agreed, and the employee is currently back on the job. ■

Plan educates clients about mental health

CIGNA attempts to shatter myths

CIGNA Group Insurance in Philadelphia and its sister company MCC Behavioral Care in Minneapolis recently launched an educational campaign to help its customers develop a better understanding of mental disability.

"We're trying to educate the employers and the employees about mental disability. We're using some information sheets we've developed as a starting point to help us talk to our customers about mental health issues," says **Kenneth Millsap**, BS, PTA, assistant vice president for loss containment for CIGNA. "We ask them to just read the sheets over and ask them if any of these points sound familiar to them."

CIGNA and MCC Behavioral Care use the following information to initiate a dialogue with customers about mental health. **(See story on Cigna's approach to mental health disability management, p. 115.)**

EIGHT MYTHS ABOUT MENTAL HEALTH DISABILITIES

1. ***Senior managers don't suffer from depression.*** Hardly true, although senior managers may be even more reluctant than others to disclose their illness. In today's highly competitive, fast-moving business environment, rising expectations appear to be pushing even more senior managers toward depressive symptoms. In one ongoing study of managers suffering from depression, 18% of the sample were senior executives "with primary responsibility and control over resources."

2. ***Women suffer from depression more than men.*** Women reveal and report their depression more than men, but this may be a self-fulfilled expectation: Because women are anticipated to be depressed more often, women are freer to reveal their depression and more likely to be diagnosed as depressed. Also, a study has shown that more men actually suffer from depression than is reported or diagnosed. The danger in this often-cited myth is that it reinforces both disability and gender stereotypes of "weakness."

3. ***Return-to-work isn't in an employee's best interest.*** Just the opposite is true. Even for employees still receiving treatment, simple accommodations usually will make it possible to return employees to full or partial productivity. Employees benefit from feeling productive again, which actually assists in achieving rapid recovery.

4. ***Return-to-work endangers co-workers.*** Although most workers returning from mental disability leave pose no threat, workplace violence is a serious issue. To reduce the risk of workplace violence, employers should encourage disclosure and treatment of depression, other disorders, and substance abuse. Unreported and untreated mental health conditions, especially when substance abuse is involved, do create risk.

5. ***Substance abuse and depression are two separate problems.*** In fact, they often are related. MCC Behavioral Care's research indicates that 50% of substance abusers had serious underlying depression. Depression sufferers try to medicate themselves, and often alcohol is the handiest drug. Alcohol, however, actually is a depressant and makes matters worse. Alcohol can trigger depression among those who may not be depressed if they begin drinking too much.

6. ***People with mental disabilities are incapable of succeeding in the workplace.*** In fact, most do quite well. For those who fail, the illness isn't the reason. Success comes more quickly and failure rates drop through thoughtful and graduated return-to-work, with temporary accommodations until the employee can achieve full productivity.

7. ***Individuals suffering from mental health disabilities are weaker than others.*** These disabilities are diseases, which may have chemical and biological components. Most sufferers can be treated and return to normal work life.

Unfortunately, the "weakness" stigma often forces individuals to hide their illness, hurting them, their families, and their businesses. As soon as the employee can return to work, employers should focus on what they can do and not on the illness. Just as we would remove physical obstacles for someone in a wheelchair, assess what obstacles can be eliminated to help an employee suffering from depression to readjust.

8. ***Acknowledging mental health disabilities will open a floodgate of claims by moody people.*** This is a management and performance issue. What should a manager do in the case of a good employee whose job performance unaccountably begins to deteriorate and who shows other signs of distress? It is important to make a distinction between poor performance per se and the precursors and indicators of depression, anxiety-related disorders, and other mental health conditions. Like so many other aspects of effective management, training is necessary to help managers deal sensitively with depression and other illnesses before they become disabling.

EIGHT FUNDAMENTALS OF MENTAL HEALTH DISABILITY MANAGEMENT

Successful return-to-work planning for mental health disabilities depends on eight fundamentals, according to the combined resources of CIGNA Group Insurance and MCC Behavioral Care.

1. Focus on returning the employees to work at the level they were functioning before they became disabled.

2. Assess the employees' life situation. Any treatment and return-to-work plan must address psychosocial factors as well as the illness.

3. Adjust workplace conditions and job requirements to assist disabled employees' transition back to the workplace. CIGNA Group's experience illustrates that most accommodations are simple and much less expensive than employers fear.

4. Concentrate on employees' strengths / abilities rather than on a particular aspect of the illness.

5. Address those symptoms that are disabling rather dwelling on the overall illness.

6. Address both medical and behavioral components in case management.

7. Assure that the needs of both employer and employee are met in return-to-work programs.

8. Establish and promote employee assistance programs, which increase productivity and help employees address issues before they become serious enough to affect productivity and availability for work. ■

Study finds patients wait years to seek help

People with social anxiety disorder suffer alone

A study presented in May at the annual meeting of the American Psychiatric Association in Washington, DC, found that most individuals with social anxiety disorder wait more than 10 years to seek treatment.

Researchers from the New York State Psychiatric Institute in New York City examined help-seeking patterns in a sample of people with social anxiety disorder who participated in the 1998 National Anxiety Disorders Screening Day.

A telephone follow-up survey of 200 screening participants who screened positive uncovered the following facts:

• Average delay from anxiety onset to first professional contact for treatment was 12.7 years.

• Average delay to confide in a friend or family member about social anxiety was 7.7 years.

• Most commonly cited reasons for not seeking treatment were:

— uncertainty about where to go for help (46%);

— problems affording treatment or lack of mental health benefits (51%);

— belief that anxiety could be controlled without professional help (21%);

— fear of what others might think (16%).

• Only 20% of patients who sought treatment were diagnosed with social anxiety disorder.

• More than half of those who did receive a diagnosis of social anxiety disorder were prescribed medications or received psychotherapy. Of those receiving medication, 70% felt their therapy was helpful in relieving their anxiety. Of those receiving psychotherapy, 86% felt their treatment was helpful in relieving their anxiety.

More than 10 million Americans are affected by social anxiety disorder, according to the American Psychiatric Association (APA) in Washington, DC. In May, the U.S. Food and Drug Administration approved paroxetine HCI, a selective serotonin reuptake inhibitor as the first drug specifically approved for the treatment of social anxiety disorder.

(For more information about social anxiety disorder, see Case Management Advisor, *May 1999, p. 81. In addition, the APA has joined the Rockville, MD-based Anxiety Disorders Association of America and the Staten Island, NY-based Freedom From Fear to form the Social Anxiety Disorder Coalition. Information about social anxiety disorder can be found on the coalition's Web site at www. allergictopeople. com.)* ■

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How to put your best practice forward

The Health Care Financing Administration (HCFA) is mandated by Section 4106 of the Balanced Budget Act of 1997 to test care coordination programs to improve the care of beneficiaries with chronic illnesses and reduce costs to the Medicare program in the fee-for-service sector.

The demonstration must be modeled on currently functioning best practices in care coordination. HCFA has contracted with Mathematica Policy Research in Princeton, NJ, to conduct the search for best practices and design the demonstration project.

For more on the project, to nominate programs for best practices, or provide general comments, contact Mathematica Policy Research, P.O. Box 2393, Princeton, NJ 08543-2393. Telephone: (609) 275-2263. Fax: (609) 799-0005. E-mail: klabounty@mathematica-mpr.com. ■

CE objectives

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

1. Develop a concise definition of disease management.
2. Select a disease management vendor for their organization.
3. List eight principles of effective mental health disability management.
4. List steps for effective evaluation of the need for environmental adaptations. ■