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Case Management ADVISOR

Covering Case Management Across The Entire Care Continuum

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Case management redesign saves millions for NM health care plan

Health plan cuts positions, slashes cost of care

When Presbyterian Health Plan merged its commercial, Medicare, and Medicaid managed care products, the case managers decided to take the merger a step further.

"When the organization made a decision to merge the product lines and we were merging the case management departments together, it was the perfect time to go further and look at everything we were doing," says **Paula Casey**, BSN, MSN, senior clinical project coordinator for case management.

By redesigning the way its case management services worked, Presbyterian Health Plan (PHP) in Albuquerque, NM, was able to decrease its number of full-time employees from 120 to 90 full-time equivalent positions (FTEs) at a savings of more than $1 million in the first year.

In 2001, the revamped case management program was able to document about $6 million in savings generated by case management interventions.

PHP serves just fewer than 300,000 covered lives spread across the entire state of New Mexico. The plan serves a socioeconomically and ethnically diverse population. Many of its members live in rural areas with few health care resources.

At the time PHP reorganized, the product lines all had duplicate departments, including prior authorization, utilization review, member services, claims, health services, and provider services. There were case managers dedicated to inpatient case management, utilization review, and concurrent review, a separate pediatric team that did its own concurrent review, outpatient case managers, an adult team on the Medicaid side, and a dedicated team for the commercial side.

"It was like we had three complete separate businesses. We threw it all up in the air and got all the managers together to think about redesigning so we could deliver better services," she added.

Dorethea Orem's Self Care Deficit Theory and the Case Management Society of America's Standards of Practice are the framework for

PHP's case management model, says **Jean Calhoun**, BSN, MSN, clinical director for case management. Orem's Theory of Self Care states that the personal care individuals require each day to regulate their functioning and development is a learned behavior. The goal is to give the client as much responsibility for self-care as possible considering his or her condition.[1]

"I want the nurses to always be thinking of how they can move the member toward optimal self-care," Calhoun says.

The administration encourages national case management certification. About 55% of the plan's case managers have become certified.

Staff in the newly combined case management department were divided into seven teams: intake and coordination; inpatient case management; ambulatory case management; medical records and research; monitoring and audit; medical directors; and financial/clinical analysis.

The ambulatory case management teams are divided into six components to deal with specialty diagnoses and to handle community-based case management in rural areas. These include high-risk medical team; catastrophic team; high-risk maternal and child team; disease management team; behavioral health team; and regional case management team.

The employees were allowed to choose the team that met their interest.

No one lost his or her job in the process. Some employees chose to transfer to other parts of the health plan. Other positions were eliminated through attrition.

"We had three sets of administrative teams with a large number of managers and supervisors. We were able to eliminate some of the middle management levels. Some went to other positions. Some changed positions within our team," Calhoun says.

When the case managers from all three insurance products were merged into one department, some of the staff were reluctant to change but "we couldn't get them to go back now. They enjoy the variety of products," Calhoun says.

All of the case managers went through cross-training sessions to learn the various product lines.

"We had to do it more than once. There was a vast amount of knowledge to learn," Casey says.

During the transition period, the managers and directors met weekly to discuss how things were going and what needed to be done.

The system has an intake coordinator who receives referrals, decides which team will be appropriate to manage the care of the referred person, and alerts the team.

Each team worked with Casey over a period of two years to develop its own criteria for which patients would fit into its portion of the continuum of care.

"Once a member hits the system, it's very easy to get hooked into the right team," Casey explains.

Referrals for case management services come from members, family members, primary care providers, or other portions of PHP.

"We are doing a lot within our health plan to obtain referrals. Anyone who touches the member, whether it's member service, marketing, or

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Editorial Questions

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

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Outcomes track benefit of case management

CMs conduct monthly analyses

Case managers at Presbyterian Health Plan in Albuquerque, NM, conduct monthly cost-benefit analyses to help demonstrate the benefits of their interventions.

In 2001, the case managers were able to show a savings in health care utilization of $6.4 million.

The process is evolving, says **Jean Calhoun**, BSN, MSN, clinical director for case management at Presbyterian.

"We realize this is still a growing item for them. We've been doing it the past two years," Calhoun says.

Here are some examples of how the case managers determine savings generated by their interventions:

The case managers look at members who are frequently seen in the emergency department (ED) or have frequent admissions. They look at patients' health care costs before they were referred to case management and for the first six months after the case managers began coordinating their care.

They can evaluate whether the patients continued with their patterns of frequent admissions or if the case managers were able to keep them out of the hospital or ED, and document the savings.

The case management department has been able to document how it can move members through the continuum of care to a more appropriate and less costly venue.

"For instance, in the past, there have been instances when a member might stay in the intensive care unit because nobody thought about moving them. If the member no longer meets the criteria, we get them moved and save the days there," Calhoun says.

When they call members to follow up on services, the case managers sometimes are able to direct the member to an appropriate level of care and avoid an ED visit and document the savings.

"I have called members who said they weren't feeling well and were thinking about going to the emergency room. I have been able to help them get in to see their primary care provider instead. Avoiding an emergency room stay can generate great savings," says **Paula Casey**, BSN, MSN, senior clinical project coordinator for case management.

The case managers have been able to save money by negotiating rates with their out-of-plan providers.

For example, one case manager was able to save a lot of money on durable medical equipment by negotiating with the provider. ■

enrollment, may refer to case management," she says.

The inpatient case manager team has been through inservices and knows the criteria for referring patients to the outpatient team.

The inpatient team work daily with the medical director to review cases of hospitalized patients and determine if they are going to need ongoing case management after discharge.

This year, PHP plans to change its focus to a predictive modeling case management system.

Staff are working to identify members who are at risk for expending large amount of health care resources and direct them into case management before the expenditures occur.

Reference

1. Orem DE. *Nursing Concepts of Practice*. Columbia, MO: Mosby-Year Book Inc.; 1995. ■

Plans reap big benefits from nurse triage services

Interventions can impact members' care

Nurse triage services offered by health plans can improve members' access to care, reduce unnecessary or avoidable emergency department (ED) and physician office visits, improve members satisfaction, and proactively identify members in need of case management or disease management services. Consider these statistics:

In a survey conducted for Intracorp, a health and disability management firm based in Philadelphia, 65% of plan members who responded said their health care actions were influenced by a conversation they had with a nurseline specialist.

In one pilot program, McKesson Health

Solutions increased enrollment in an asthma disease management program by more than 30% by identifying people through its nurse triage line.

A third of members using either Intracorp's nurseline or case management services said the program increased their overall satisfaction with their health plans.

Both Intracorp and McKesson Health Solutions provide nurse triage lines and other services to a variety of clients, including payers.

Representatives of both companies report that their clients have found the nurse triage lines beneficial in directing members to the appropriate level of care.

"Data from the National Center for Health Statistics and the Agency for Healthcare Research and Quality show that 54% of emergency room visits are for nonurgent care and that nearly 60% of physician visits are for information and reassurance vs. hands-on care," says **Kevin Maher**, RN, vice president of product management for CareEnhance Services at McKesson Health Solutions.

Purchasers of nurse triage services typically want to improve their membership's access to care and reduce unnecessary and avoidable ED and physician office visits, Maher says.

"Members should be able to get health care information through the provider network, but after hours and on weekends, it can be a challenge," he adds.

That's why nurse triage lines can be useful in providing information to consumers that helps them avoid a visit to the physician's office, or redirecting their care to a venue less intensive than the ED, he adds.

The goal of a nurse triage service is ensuring the health of the caller, which may mean treating a medical condition at home, the physician's office, or the ED, whichever makes the most sense for the condition described by the health plan member, Maher says.

"Nurse triage lines help the consumer decide if an acute medical condition should be handled at home or at the emergency room," he adds.

The savings can be substantial, says **Kathleen M. Leone,** vice president, utilization management for Intracorp's Health Care Management unit. **(For details on Intracorp's nurselines, see related article, right.)**

Intracorp partnered with CIGNA HealthCare and Watson Wyatt, a human resources consulting firm, for a study to quantify the value of health information lines.

The researchers concluded that a call to a health information line or nurse triage line reduced costs for the majority of 10 conditions evaluated because the callers were guided to an appropriate level of care.

During the eight-month study, Watson Wyatt identified the top 10 conditions about which members called the health information line. They compared claims data on the 10 conditions from eligible members who called the health information line and those who did not.

The top conditions were abdominal pain; sore throat; chest pain; trauma — lower extremity; fever; cough; trauma — bone, ligament, or muscle; flulike symptoms; earache/ear pain; and backache/back pain.

In all conditions except chest pain, the outpatient cost was lower for those who called the health information line than for those who did not. In the case of chest pain, the researchers concluded that the callers were triaged to a more intense level of care, which was appropriate.

In many cases, the savings were significant. For instance, with lower trauma, the average outpatient cost per caller was $52.55, compared to $218.53 for those who did not call the health information line. For people complaining of fever, the cost was $111.80 for callers vs. $236.95 for noncallers.

In another study, when McKesson Health Solutions merged the claims data records with patient call records for three different health plan clients, one of which has 4.4 million members, the researchers discovered that about 40% of people calling the nurse triage line had had a chronic, catastrophic, or mental health claims in the year in which they called.

As a result, callers to McKesson's nurse triage lines now are asked to participate in a mini-health assessment screening. If they appear to be at risk for chronic illnesses, they are referred to the health plan's case management or disease management programs. **(For details, see related article on p. 66.)** ■

Nurseline service saves lives, costs for employers

Program generates loyal customers

A truck driver for a large freight company was hundreds of miles from home when he began having chest pains.

He used the cellular telephone supplied by his employer to call the nurseline, operated by Intracorp, a Philadelphia-based provider of health and disability services for insurers, third-party administrators, employers, governments, and managed care organizations.

The nurse listened to his symptoms, determined he probably was having cardiac-related symptoms, gave him information about the nearest hospital, and encouraged him to go there.

The truck driver went to the hospital where he got the care he needed to save his life.

Success stories like the truck driver's are one reason that employers see a big benefit in contracting with companies that provide nurse triage services, says **Kathleen M. Leone,** vice president, utilization management for Intracorp's Health Care Management unit.

"We have a lot of loyal customers because these types of products, in their judgment, have been proven time and time again."

Nurseline savings

Intracorp's nurseline programs serve nearly 14 million consumers a year.

The company has more interest in its nurseline products today than ever before as more and more employers struggle to manage health care costs, Leone says.

"Employers see the benefit in providing their workers with these tools to allow them to take greater control of their own health," she adds.

However, statistics have shown that only 15%-20% of employees who are eligible use the Intracorp nurselines.

As a result, Intracorp has developed an initiative to encourage employers to communicate with their employees about the benefits of calling the nurseline with their health care questions.

The company has put together a collection of low- or no-cost tactics an employer can use to increase utility and awareness of the nurseline.

"We believe that the more they do to encourage the use of the nurseline, the more savings they will actually see," Leone says.

Much of the savings from nurselines is generated because the nurses are able to direct members away from the ED for care and to a more appropriate and less costly setting, she adds. **(For details on savings generated by nurse triage lines, see article on p. 63.)**

Intracorp has had nurseline since the early 1990s. The company offers three different types of product to meet the needs of a variety of different customer segments, from small employer organizations to very large managed care companies.

The company provides three levels of nurse support. The basic level offers 24 hours of nurse support, including information and triage. The next level also includes access to an audio health library with more than 1,100 topics and a more comprehensive communication packages for the employer to use.

The top level also includes proactive outreach, such as providing information for members who are scheduled for surgery and making follow-up calls after they are home.

"Not everybody who has an inpatient stay should be in case management. Nurseline nurses can provide the necessary support and education for some situations," she adds.

All of Intracorp's nurseline services are based on nurse availability 24 hours a day, seven days a week.

"If a consumer has any need to talk to a nurse, they can call the nurse line and get information and some guidance about whether care should be in the hospital, the doctor's office or if self care can be possible," Leone says.

The nurses themselves do not make the decisions but arm the consumer with as much information as possible so the consumer can make the decision, she says.

The nurses match up information about the patients' condition with nationally recognized decision-based guidelines that help them make a recommendation. The nurseline nurses have the same information as the case management or disease management nurses, so information at any point in a patient's care is consistent.

The services include answering medical questions, providing self-care techniques for common symptoms, explaining treatment plans and technical terms, and helping consumers get access to in-depth, evidence-based information online.

If a caller to the nurseline is in a disease management program or currently in case management, the nurse can access all the patient information and help the caller make decisions based on that information.

"Whether it's a case manager, a nurseline nurse, or a utilization manager, they all have access to the same case files and can add notes to it," she says.

For instance, if a patient who is being followed by a case manager for a particular condition calls in the middle of the night, the nurseline nurse alerts the case manager, who has immediate

Triage line screens callers for chronic disease

Program identifies members for programs

When members call a nurse triage line about a health problem, they're at a "teachable moment" when they are receptive to taking action about their conditions, **Kevin Maher**, RN says.

That's one reason McKesson Health Solutions began screening callers to its nurse triage line to determine if they may be at risk for chronic illnesses or other high-cost conditions, says Maher, vice president of product management for CareEnhance Services.

"The real power is that you are catching members at a time when they are more inclined to listen, rather than calling them on an outbound basis when they may not be experiencing any problems," Maher says.

McKesson began the screening process when an analysis of nurseline data and claims data showed that 40% of the people who called a nurse triage line had a catastrophic, chronic, or mental health claim in the year in which they called. "Health plans are looking for new value from these services. One way to get more value is to use the nurse triage line as a way to identify members who are at risk and refer them into disease management or case management," he adds.

Now when members call, the triage line nurses ask if they want to learn more about programs available through their health plan.

If the caller answers yes, the nurses conduct a mini-health risk assessment and use the data they receive as a guide to channel members into case management, disease management, wellness programs, or mental health programs.

"This enables our clients to help connect the dots and identify members with problems much earlier, rather than waiting for claims to show up," Maher says.

The program has identified a sizeable percentage of members who have a chronic condition or one that makes them eligible for case management but who have not turned up in the health plan's programs.

About 70% to 80% agree to take the survey. Among the members who are identified to be at risk, about 70% to 80% agree to be referred to a program, Maher says.

The screening eliminates members who already are in a case management or disease management program.

The program has a high success rate because it catches the members at a time when they are concerned about their health.

"Screening tools are an excellent way to predict risk, but it's highly effective when you use a combination of assessment tools and a motivated member," Maher says.

The nurses automatically ask all callers to participate in the screening, with the exception of those members who need to seek care immediately.

Once the health risk assessment identifies members in need of services, the triage nurse connects them to the health plan's programs in a variety of ways, depending on the contract the plan has with McKesson.

They can be transferred directly to a case manager or, if it's after hours, the triage nurse will find out a good time for the case manager to call the member and forward the information to the case manager.

"This does more than just take care of the immediate problem about which the member called. It identifies members who can benefit from other programs the health plan has in place," he says. ■

access to the nurseline nurse's notes and can act accordingly.

"It's a seamless operation. Our products are very well integrated," Leone says.

The nurselines are extremely popular with consumers, who give a lot of positive feedback on Intracorp's annual customer satisfaction surveys, Leone says.

In addition to answering the questions, many respondents write in additional comments about how the nurse helped them understand what they needed to do, kept them calm in an emergency situation, such as a child's asthma attack, and gave them advice that they found to be helpful.

"A lot of it is peace of mind," she says. All of the company's services are on one platform with the patient at the center. ■

Nurses help members navigate system

Callers get information on conditions, benefits

HealthPartners of Minneapolis has created a program that bridges the gap between the health plan's member services line and the after-hours nurse triage line.

The Nurse Navigator program, launched in August 2000, is staffed by nurses who answer questions about medical conditions, clarify benefits related to medical conditions, facilitate the benefits in complex cases, help members find credible medical information on the Internet, and link members with appropriate providers and services.

When **Scott Aebischer**, the plan's vice president of customer and member services, began working with the plan's call center, he noticed that a lot of members were calling in for help in learning how to get treatment for complex medical needs or chronic conditions, and operators at the health plan's member services line were not equipped to handle the calls.

"A lot of these callers to member services had just been diagnosed with a condition. They wanted to know who they should see, how do they set it up, and how it relates to their benefits," Aebischer says.

The member services operators could easily handle calls that involve claims inquiry, benefit information, change of addresses, new identification cards, and other topics.

Managing logistics of care

"Member services representatives don't know about medical care and treatment. They don't know about conditions or pharmacy or the medical industry. They know about benefits and how to help people find out about their health plan," Aebischer says.

HealthPartners created the Nurse Navigator program in August 2000 as a way to supplement its other telephone services to members.

This was an area where the level of frustration of the members was easily resolved," he adds.

The program is staffed by five nurses who deal with commercial members and three who handle the government-related insurance business.

The nurses are housed within the member services' sections.

When a member calls in to member services during regular office hours with needs the Nurse Navigators can handle, the representative puts them on hold and alerts the Nurse Navigator.

The Nurse Navigators have been training to talk with members about their benefits and their medical conditions as well.

For instance, if a member has been prescribed a new drug, the Nurse Navigators can help them understand what it is and how to take it.

"They manage the logistics of care," Aebischer adds.

The Nurse Navigators have access to the health plan's benefits on-line and can work with each individual to maximize them.

For example, if the benefits don't allow the option the member wants to pursue, the nurses help him or her find someplace that does work.

"We are changing the process. Rather than working with the benefits after the fact, we are helping them make the choices in advance," he says.

Suggesting options

For instance, if a member wants to go to the Mayo Clinic and the benefits don't cover it, the Nurse Navigators might help him or her find a physician who trained at Mayo.

If a member calls in and has been prescribed a drug that isn't in the HealthPartners formulary, the Nurse Navigator may tell the member about other, similar drugs that are covered and suggest that they discuss it with their physician. In some cases, the Nurse Navigator may call the provider to see if he or she will prescribe the similar drug that is covered.

"The nurses help the consumers with their role in discussing the situation with their provider," Aebischer says.

Nurses who answer the health plan's Careline, an after-hours nurse triage service, also refers people with complex needs to the Nurse Navigators.

For example, a member may call the Careline to find out about gastric bypass surgery and be referred to the Nurse Navigators for information about whether his or her benefits cover gastric bypass surgery and what criteria he or she may meet.

Nurse Navigators who are specialists in geriatric care help Medicare beneficiaries get through the Medicare maze, explaining what the terms mean

and making sure they get to the right physicians.

They help people find community programs that will help them. If they need durable medical equipment, the Nurse Navigators explain what it means and help them find something that will meet their needs.

"Providers are doing everything they can, but often members are listening only to part of what a caregiver says. When they get home, they have a lot of questions. In the past, they'd call their doctor; but these days, the clinics are so busy they may not be able to get an answer quickly," Aebischer says.

In 2001, the nurse line received 13,861 calls and made 37,974 outbound calls. By 2002, the number had increased to 22,768 inbound calls and 42,916 outbound calls.

"The response has been enormously positive, as shown by the steady increase in call volume as well as from individual success stories by members," he says. ■

Document outcomes to prove your value

Tallying soft savings is not enough anymore

Today's case managers need to understand outcomes and track them in order to prove that their interventions have value, says **Mary Jane McKendry**, RN, CCM, MBA, director of education, training and consulting for McKesson and is president-elect of the Case Management Society of New England in Hampstead, NH.

"Case management is at a crossroads. We know that case management brings something valuable to the table, but now we need to clearly define the ways to accurately measure the results of our interventions and design a way to report on it," she says.

Outcomes result from interventions

She is a member of the Case Management Leadership Coalition (CLMC; www.cmleaders.org), a group of leaders representing a broad cross-section of the case management field, formed to address the challenges facing case managers in a changing health care environment. McKendry is on the CMLC task force researching quality and outcomes reporting metrics and return-on-investment tools and strategies.

Simply put, outcomes are the end result of the interventions a case manager performs, McKendry says.

In the past, case managers have faced challenges in documenting their interventions because most often they didn't have the software to use, there were no processes in place to document outcomes, and there were no hard-and-fast rules about what to document.

"Case managers have faced challenges in documenting their outcomes because they didn't have the supporting software or hard-copy applications to track outcomes, or they were too busy to document them," she says.

Cost-benefit analysis

McKendry recalls that in a previous job, she realized that she was able to call as many as three clients in a 15-minute period and make really good decisions and/or suggestions about the clients' care, but that it would take an hour or longer to document the discussions.

Most case managers who document their outcomes have had to learn how to do it by the seat of their pants, she adds.

In many cases, the interventions have been driven by what the organization wanted the case managers to do. For instance, in workers' compensation, many case managers are pressured to document return to work, and companies tout their success in returning people to work.

"Nobody was measuring successful return to work. If we got them back to work quickly and they weren't ready and they were re-injured, you wonder how successful the intervention was," McKendry adds. The better outcomes to measure would be successful return to work, she says.

Some case managers have been doing cost-benefit analysis and documenting soft savings, but many people haven't paid attention to this because it hasn't been hard dollars, she adds.

The challenge is how to take the global case management strategies such as assessment, planning, implementation, and evaluation and build models that work for organizations to track what case management interventions are done, what outcomes should be observed, and how to appropriately report on them, McKendry says.

"Chances are that we document only the most critical interventions. We are making interventions we can't quantify or not documenting what we are doing," she says.

Determine what to track and how to track it

Outliers, costly diagnoses are a place to start

Before you start your outcomes measuring program, you need to decide what you're going to track and how you're going to document your savings.

Mary Jane McKendry, RN, CCM, MBA, director of education, training, and consulting for McKesson and is president-elect of the Case Management Society of New England, suggests starting with your frequent diagnoses, your costly diagnoses, or your outliers, and track what you do for these, what your interventions are, and how the interventions affect the outcome.

One measure would be to pull data on the "frequent flyers," those who had three or more ED visits for the same or a related diagnosis in the past five months, she says.

Look at what is going on with each patient. Assign them to case management and have the case manager do a typical assessment and track all their interventions.

Find out why their patients are having trouble with their treatment plan and why they are making ED visits. It may be that they can't get their medication or they stopped taking it because it made them sick. It could be that they don't know how to monitor the signs and symptoms of their disease and, when they call the physician's office, they are put on hold and they don't like to wait.

Interventions may include making weekly calls to members and helping them overcome their problems in compliance. If a client says she isn't feeling well, the case manager may counsel the client to see her physician and help her get an appointment before her condition gets worse. The case manager may help clients get their prescriptions filled or empower them to ask questions of their providers.

After a period of time, say six months, measure how many urgent visits they made, compared to the six months before they were in case management.

"The case manager can show that the calls she made to the patient can be related to a decrease in urgent visits, which saved this amount of money," McKendry says.

Another way to identify the impact of interventions on outcomes is to focus on several diagnoses and compare the data before and after you began case managing the patients.

Start out with the two or three diagnoses you know you handle well. They could be a diagnosis such as myocardial infarction or diabetes, where there are a lot of protocols.

Then take another diagnosis where the patients are difficult to manage, where some are compliant and some aren't, such as congestive heart failure.

Pull the data for the year before you started tracking and compare them to the current year. Track how long the average person stayed in the hospital or how long it took for them to move through the continuum of care.

You might start out with the most expensive diagnoses or begin with two or three high-cost diagnoses you know you manage well.

Start tracking these diagnoses and add to the list of diagnoses to track after you have figured out the best way to track interventions and outcomes with the first few.

For instance, you could start making weekly calls to all congestive heart failure patients to make sure they know how to measure their weight and check their respirations. Prompt them when it's time for them to see the physician.

Measure the interventions against the previous six months. Then you might include working with the hospital case managers to make sure the patients are educated about their disease and linking them to a disease management program.

"Case managers do this with every congestive heart failure; but in the past, they haven't measured it," McKendry says.

Look at the population that has had these interventions and that which has not and do a comparative study.

When you look at the population you have managed and see that some still have frequent admissions, look at the individual patients to see what is going on and whether you need to change your approach. For instance, if the case managers are just sending postcard reminders to patients, you might consider calling the outliers.

After you change your interventions, measure again to see if they work. ■

It is critical for case management departments to be able to take what a typical case manager does and link it to cost savings or good outcomes, she adds. The information has to be in a form that can be used to generate a report that documents the related savings.

"It happens every day. The patient has a concern. The case manager discusses it and directs them to the right care, helping them avoid an emergency room visit or exacerbating their condition so much that he or she needs to be hospitalized. These are important interventions, and we

have not done a good job of documenting them, or we document them in a narrative form," McKendry says.

McKendry suggests that case management directors collaborate with their information technology staff to create a way to measure outcomes and quantify the impact of interventions. Some case management departments have used an off-the-shelf spreadsheet program to track their interventions, she adds.

If your computer technology isn't sophisticated enough, create a paper worksheet that case managers can use to jot down their interventions. The information can be put into the organization's data warehouse, she adds.

Start by listing the typical interventions that case managers do in a way that makes it easy for the case managers to check them off. With a software application, there can be a screen with places for the case managers to check off what they did.

Even with paper copies, it's easier to document in an outline format than in a narrative form, and it is easier to generate reports later on, she adds.

Examples of hard savings

Every time a case manager does something for a patient, he or she should fill in the data and transmit them to wherever your data are stored.

Come up with a way to measure how a case manager's interventions have an impact on the quality of life, clinical, and financial aspect of care.

Link what you do to those three markers: Clinically, the patient is doing what he or she needs to do and knows where to get help. The patient's quality of life is better because he or she feels better. The company is financially better off because the patient requires less urgent care and fewer visits to the physician's office.

"Case managers have to be able to define in some kind of format the things they do, when they do them, and the impact they have. It's not just that they make calls, it's what they learn when they call, and what they then do with the information," she adds.

For instance, if you call members with congestive heart failure to check on their weight, be able to document that, if they had gained weight, you helped them to get in to see their physician. Then you could include in your report that you helped the patient avoid a potential admission.

Here are some examples of hard savings that can be documented:

- A case manager calls a patient with a chronic disease who says he isn't feeling well and the case manager urges him to call the physician rather than waiting for the condition to get worse and ending up in the ED.
- A case manager coordinating care for an injured patient calls the physical therapist who expresses concern that the patient is experiencing extreme pain and isn't making progress. She plans to include it in the report to the physician in two weeks.
- The case manager talks to the patient and suggests that he call the physician for an early appointment. The physician finds that the injury isn't healing right. The case manager has prevented the member from re-injuring himself and can document this. ■

CM can help patients better control chronic conditions

Survey identified five 'steps to success'

Case manager interventions can benefit patients who are dealing with chronic conditions, a member of an advisory board working to improve health care says.

Chronic Care in America, a comprehensive study of behaviors across chronic conditions, demonstrates why some people succeed and other struggle to manage their conditions.

The survey identifies five "steps to success" based on the behavior of people in the survey who indicated that they have succeeded in managing their conditions and observations from physicians.

Steps to success

Case managers can help patients take these steps to success by working with the patients and their physicians to coordinate care and information, says **Gerard Anderson**, PhD, a professor at Johns Hopkins University in Baltimore and director of the Partnership for Solutions, a program funded by the Robert Wood Johnson Foundation.

"We need somebody in charge of delivering care for people with multiple chronic conditions who deal with multiple doctors. That's where case management is important," Anderson says.

Here are the steps to success and Anderson's suggestion of how case managers can be involved:

1. Get a "prescription for information."

Patients who view themselves as being most successful at living with their condition also are those most likely to read about their condition, the researchers found. While patients are accessing health information on the Internet, 86% report that they rely more on their physicians for information.

"Getting information to the patient in a way he or she can understand is a critical role for case managers, and it's not a role that physicians typically play. Case managers should step up to the plate and make sure the patients get the information they need," Anderson says.

2. Be aware of depression.

Depression affects 25% to 33% of people who have a chronic disease, the researchers found. Less than half the patients who reported they had been diagnosed with depression had been successful at managing their condition.

"Depression is harder to detect, but it may have a more profound effect than other diseases. Case managers don't always recognize depression as a comorbidity, but they should be aware that they are going to be dealing with a high percentage of patients with some level of depression," Anderson says.

He suggests that case managers be on the lookout for signs of depression in their chronically ill patients and use their clinical judgment to decide whether the patients need interventions.

3. Make the physician a partner in care.

It's vital for the case managers to get involved in this initiative and coordinate the care the patient receives from all physicians, Anderson says.

Patient reminders

"When patients are dealing with five or 10 different clinicians, the case manager is the one person who has the role of being care coordinator for all the conditions. When specialists have patients with comorbidities, they are likely to treat one condition but not the others," Anderson says.

He suggests that case managers make sure they keep reminding patients to alert their physicians to all of their other conditions when they are being treated for one condition. Case managers should work with physicians to make them aware of the comorbidities, the care the patient is receiving from other physicians, and other issues that arise, he adds.

4. Take action immediately after your diagnosis.

People who successfully managed their chronic conditions responded quickly to make lifestyle changes, while 65% of the unsuccessful patients said they wished their condition would "just go away."

Case managers should make sure there is immediate follow-up when patients are diagnosed with chronic conditions, Anderson adds.

"They may have to become coaches for care or cheerleaders for some patients, encouraging them to be compliant with the treatment plan," he says.

5. Make a health investment in you.

"We know that patients don't take their prescription drugs or stop smoking and that they behave inappropriately. Case managers have an important role in helping patients make lifestyle changes," he adds.

(Editor's note: For more information on dealing with patients with chronic illnesses, see www.partnershipforsolutions.org.) ■

CE instructions

CE subscribers participate in this continuing education program by reading the articles, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers and refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. The semester ends with this issue. You must complete the evaluation form included in this issue and return it in the provided reply envelope that is addressed **"Education Department"** to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

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CE questions

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21. In 2001, the revamped case management program at Presbyterian Health Plan in Albuquerque, NM, was about able to document savings generated by case management interventions of what amount?
A. $3 million
B. Just under $5 million
C. About $6 million
D. More than $10 million

22. Which of the following was not one of the top 10 conditions about which members called Intracorp's health information line?
A. Abdominal pain
B. Blurred vision
C. Sore throat
D. Earache/ear pain

23. The nurseline program at HealthPartners of Minneapolis received ____ inbound calls in 2002.
A. 22,768
B. 13,861
C. 37,974
D. 42,916

24. According to Mary Jane McKendry, RN, CCM, MBA, president-elect of the Case Management Society of New England, case managers have faced challenges in documenting their outcomes for which of the following reasons?
A. Lack of cooperation from physicians
B. Lack of interest in outcomes by administrators
C. Governmental regulatory concerns
D. Lack of supporting software or hard-copy applications to track outcomes

Answers: 21. C; 22. B; 23. A; 24. D.

CE objectives

After reading this issue, continuing education participants will be able to:

1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how those issues affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities. ■

Reports From the Field™

Asthma treatment, medication survey available from AHRQ

More than 6.5 million adults and 3.2 million children have an asthma attack each year, according to data collected in 2000 by the Agency for Healthcare Research and Quality (AHRQ).

A physician or other health care provider has told more than 25 million Americans that they have asthma, the report says.

The data are from the AHRQ's Medical Expenditure Panel Survey, which collects data each year on health care costs, use, and access from a sample of 10,000 households and 24,000 individuals. Here are some statistics:

• Among people who had an asthma attack, more than half of the adults and more than 40% of children reported using inhaled corticosteroids.

• Children between the ages of 0 and 17 (91.2%) were more likely than adults (84.3%) to use asthma medication other than inhaled steroids.

• Nearly a third of the population who reported an asthma attack in the last 12 months reported having a peak flow meter in their home.

More information on the study is available on-line at www.meps.ahrq.gov/PrintProducts/PrintProd_Detail.asp?ID=489. ▼

Average hospital stays shorter, CDC reports

The 32.7 million patients in the nation's hospitals in 2001 had a much shorter average stay (4.9 days) than patients in 1970, who were hospitalized for an average of 7.8 days, according to the National Hospital Discharge Survey from the Atlanta-based Centers for Disease Control and Prevention (CDC).

The most dramatic decrease was for elderly patients, whose hospital stay in 2001 was 5.8 days, less than half of the 12.6 average stay in 1970.

In 2001, as in the previous year, the most frequent reason for hospitalization was heart disease. While the rate of hospitalization for most conditions has decreased, congestive heart failure (CHF) hospitalizations increased by 62% from 1980 to 2001, according to the report.

The report attributed the increase to success in treating more acute forms of heart disease, extending the life of many people and making it more likely they will develop a chronic heart problem such as CHF.

Cardiovascular procedures were performed on one-fifth of the men hospitalized in 2001 but only 10% of the women.

Other major reasons for hospitalization were psychoses, pneumonia, cancer, and fractures.

The report, conducted by the CDC's National Center for Health Statistics, includes data from all nonfederal short-stay hospitals in the United States. A copy of the report is available at www.cdc.gov. ▼

Employer group report cards don't improve quality

The majority of hospital report cards created by employer groups do not improve the

quality of care, according to a new report.[1]

Researchers, led by **Ateev Mehrotra**, MD, MPH, of the Harvard School of Medicine, interviewed leaders of employer coalitions who created the report cards and hospital representatives in 11 communities to find out what effect the report cards had on quality of care. The communities ranged from metropolitan areas to rural areas.

Report cards, grading and comparing a community's hospitals based on factors like hospital death and average lengths of stay, are becoming more popular, Mehrotra says.

"Although this trend is still in its infancy, our analysis found that only a few existing report cards have stimulated quality improvement. However, those that were successful demonstrate their potential impact," he adds.

The report suggests that hospitals and employer groups distrust each other's motives. Hospital officials often suspect that quality initiatives recommended by the report cares really are about cost and object to using billing data to measure quality, the researchers say.

Reference

1. Mehrotra A, et al. Employers efforts to measure and improve hospital quality: Determinants of success. *Health Affairs* 2003; 22:60-71. ■

Disabled Medicaid patients fare better when they direct their care

Medicaid recipients with disabilities who direct their own supportive services were significantly more satisfied and appeared to get better care than those receiving services through home care agencies, according to a demonstration project supported by the U.S. Department of Health and Human Services and the Robert Wood Johnson Foundation.

Participants in the project, which included both elderly and nonadult Medicaid recipients, were given an allowance and a high degree of flexibility and freedom to choose personal care assistants.

The study compared the outcomes of traditional care that is agency-directed with care that is directed by the recipient.

• Reports of paid caregivers failing to complete tasks was about 60% lower in the group that directed their own care.

• Those who directed their own care were at least as safe as those receiving agency-directed care, as reflected in reports of adverse events, health problems, and general health status.

• Program participants were nearly 20 percentage points more likely than the control group to express satisfaction with their lives.

The study is available on-line at 222.healthaffairs.org/WebExclusives/Foster_Web_Excl_032603.htm. ▼

Brain injury patients turn to alternative medicine

Patients with traumatic brain injuries are turning to complementary and alternative medicine (CAM) therapies to supplement conventional medical care, but the majority is not discussing it with their physicians, a new study has concluded.

Research presented at the American Academy of Neurology meeting in April revealed that more than 80% of patients interviewed believed that alternative therapies, ranging from massage to herbal medicine were effective even though there has been little medical research to prove it.

Researchers at the University of Michigan's (U-M) Health System's Department of Physician Medicine and Rehabilitation interviewed 130 randomly selected brain injury patients. More than half said they had used at least one CAM therapy. The most commonly utilized were massage therapy, meditation, herbal medicine, and chiropractic care.

To learn more about the U-M traumatic brain injury program, visit www.umich.edu/pmr. ■

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