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Health plan tailors medical management programs to individual organizations

Data-driven program helps develop solutions across the continuum

By identifying the most costly conditions for the health plan and for specific employer groups, Regence Blue Cross Blue Shield of Oregon (BCBSO) has been able to tailor its medical management programs to fit individual organizations and bridge the gap between various components such as case management, disease management, and pharmacy management.

The Portland-based health plan started by looking at claims data for the entire covered population and by large employer groups for the most costly diagnoses. Then it used the data to target the employers for programs dealing with disabilities and conditions that affect them more than anybody else.

"What is important is that every health plan look not just at what is popular but at what is going to have the biggest impact. That's where the data-driven piece comes in," says **Patrice Korjenek**, PhD, assistant vice president of health economics for the health plan.

The analysis came up with four categories that account for about half of Regence BCBSO spending — heart disease, cancer, gastroenteritis, and orthopedics, Korjenek says.

"Essentially, the information gives us clinical targets that affect the bottom line. The idea is to identify the needs of individual organizations and have all the different pieces of medical management, including case management and disease management, work collaboratively to come up with ways to intervene," she adds.

The typical insurer looks at the same hot diagnoses, such as diabetes, heart disease, and depression for its disease management and case management programs, Korjenek points out. The diagnoses are popular because they occur frequently, cost a lot, and there are gaps between the ideal treatment and the vast majority of practices," she adds.

"Until we looked at the orthopedic claims data, we would never have focused on people having back surgery. It happens frequently, but it's not usually an acute case, so we wouldn't have focused our disease

management or care management programs on back surgery," says **Annie French**, RN, manager, health care management.

The same conditions that affect the population as a whole by and large affect the employer groups, but the emphasis may be different from employer group to employer group, she adds.

For instance, gastroenteritis is one condition that accounts for a high degree of cost. In one employer group, the cost may be gastroesophogeal reflux disease (GERD). In another, the high cost may be the result of employees choosing to have their appendectomies in the most expensive facility in town, she adds.

"We can look to see what is unique about each employer group that drives their health care spending," she says.

The health plan takes specific information for a particular group, looks at their health care spending, and comes up with programs Regence BCBSO believes would be a good investment for the employer.

"Using the data gives us a higher percentage of appropriate sales of our program. We are better able to match the need of our program to the specific employer groups, rather than just try to sell the programs to everyone," Korjenek says.

The disease management department takes the information on the high-cost diagnoses by employer groups and looks for opportunities for improvement and interventions each group should consider, says **Sonja Thygeson**, BS, MPH, manager, disease management programs.

"We take into account aspects such as average length of employment and how long their participants have been eligible for the programs. For instance, if an employer has a lot of turnover, a comprehensive disease management program may not be a good investment," Thygeson adds.

An organization with a young and healthy population probably wouldn't need the Special Beginnings program for high-risk pregnancy but might need a program to help manage back pain, French says.

"Once we have identified a recommended program or a set of programs, we put together a detailed business case that outlines the rationale for our recommendation," she adds.

At the same time, the organization has been able to create more integrated medical management programs that bridge the gap between case management, disease management, pharmacy management, and health promotion departments.

"We are stretching the boundaries of case management. We are no longer sticking with the catastrophic, acute-care management. We are aligning with the disease management services and moving toward the middle," French says. **(For a look at how the programs work, see p. 75.)**

By using the data generated by Korjenek's department and working closely with disease management, the case management department has been able to take a more in-depth look at the population it serves, and take a proactive approach to members whose conditions have not yet become catastrophic, she adds.

"In the past, the way we have identified members for acute catastrophic case management was to get the information from the claims data. If you wait until there is a claim, it's too late to have

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Editorial Questions

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Comprehensive program bridges gap between CM, DM

Departments work together on integrated plan

Often in health plans, disease management is in one silo, case management is in another, pharmacy management is in another, and they may not interrelate.

Regence Blue Cross Blue Shield of Oregon (BCBSO) is trying to change all that by creating a comprehensive medical management program that includes case management, disease management, and other programs, including network design and physician education.

The data-driven program helps bridge the gap between case management and disease management, providing case management interventions across the continuum.

"We try to use the information we have gleaned to pull the whole process together," says **Patrice Korjenek**, PhD, assistant vice president of health economics for the Portland-based health plan.

The medical, case management, and disease management staff at Regence BCBSO get together monthly to discuss the groups they are working with possible interventions that would be beneficial, and who should be handling a typical member's care. For instance, members in case management who are too ill to be in disease management are transitioned after they improve.

Korjenek's department examines claims data by employer groups to identify the conditions that have the highest cost for each company. Then the disease management and case management staff come up with an integrated implementation plan and communication strategy, tailored to the specific employer.

For example, one employer was concerned about its back surgery expenses and wanted a pilot project to try to cut costs, says **Sonja Thygeson**, BS, MPH, manager, disease management programs.

The plan Regence BCBSO came up with included collaboration with the health promotions department to develop educational materials, a disease management program that followed specific protocols, and a case management program that provides interventions when needed.

"Orthopedics was a costly condition for this employer group. When we dug deeper, we found that back surgery was a significant driver. We felt like interventions for low back pain could make a bigger impact than interventions for other conditions," Thygeson says.

The back pain program is coordinated internally at Regence BCBSO with the help of a vendor that does telephonic health coaching specifically designed for people who are having back problems such as herniated disk and may be considering surgery.

"We are working through our health economics department to identify people through claims data who may be on the path for back surgery," Thygeson says.

When members are identified as a potential for back surgery, case management staff contacts them, have them fill out an assessment, and stratify them. If the members are having low back pain but it's not severe and they haven't been considering surgery, Regence BCBSO sends them basic educational materials developed by the insurer's health promotions department. These include home treatment and self-care for managing back pain.

The case managers act as intermediary and communicate information to the members.

If the members are considering surgery, they are enrolled in the vendor program and work with a health coach who helps them understand their treatment options and make an informed decision.

Regence BCBSO reports regularly to employer groups, including data from case management and disease management along with pharmacy data.

"The employer is able to look at all our medical management intervention strategies and the results all at one time," Korjenek says. ■

a big impact," French points out.

Having comprehensive data on specific employer groups allows the company to be proactive instead of reactive, French says.

The data help the insurer identify members who are at risk early on, before they are hospitalized and need catastrophic case management.

"We are expanding the boundaries of typical case management and using more of a disease management approach," French says.

For example, French uses the data to choose which groups to approach for the Special Beginnings program for high-risk pregnancy.

"We look at the demographics of the group, the number of pregnancies they are having, and make a determination of which employer groups would be a good candidate for the high-risk pregnancy program," she says.

This way, the company can provide targeted interventions and then show the impact of the interventions.

"One of the problems we've had in case management is that although we know we bring a lot of value to the table, we have not had the means of proving it," French says.

In the case of the group that prefers the most

expensive hospital, the Regence BCBSO representative may approach the employer group and point out that it is paying an average of $4,000 more per case to send employees to that particular hospital.

"Often the group had no ways of knowing why their costs were high. This could lead to a change in benefits. The data give us the ability to go to an employer group and be specific about why they are paying what they are," Korjenek says.

Other employer groups have a high cost because of a frequent incidence of GERD, a condition that is associated with lifestyle.

The Regence BCBSO representative may suggest a program through health promotion and education, pharmacy management, or case management to direct members to the most effective medication.

"There are a lot of medications for GERD that are highly advertised. People get prescriptions for the next version and the next version, and it can go on forever," Korjenek points out.

Case managers or disease managers can educate members that medication is supposed to be short-term and that lifestyle changes will have an effect, she adds. ■

DM program targets low back pain

Goal: Save costs, improve patient quality of life

Low back pain is the second most frequent reason for physician visits, the fifth most frequent reason for hospitalization, and the third most frequent reason for surgical procedures.

That's one reason CIGNA Health Care, based in Bloomfield, CT, has developed a low back pain disease management program

The program includes education, telephonic intervention by disease management nurses, depression screening, tips on how members can decrease their pain and stay active, and working with the physician's plan of treatment.

"Low back pain is one of the most common health problems in the United States, affecting as many as 45% of Americans each year. Having a history of low back pain is one of the most reliable predictors of having subsequent problems," says **Mary Jane Osmick**, MD, senior medical executive for the disease management program and health facilitation for Intracorp, a subsidiary of CIGNA HealthCare.

About 70% to 80% of all Americans experience muscular low back pain at some point in their lives. According to the American Academy of Orthopaedic Surgeons, about 90% recover within six to 12 months, but 75% relapse within a year.

"There is a huge population of people who experience low back pain on a regular basis. It tends to recur and can lead to disability and potentially even surgery if it's not handled properly," she says.

The insurer revamped its low back pain program in October 2000. About 108,000 members are enrolled in the program. Osmick is anticipating a 7% cost savings from the program based on research, although it's too early to have any firm figures at this point, she says.

Until a few years ago, practitioners believed that bed rest was the best way to treat muscular low back pain.

"Treatment of muscular low back pain has now been studied, and our beliefs have changed. The reality is that literature suggests that staying moderately active with muscular low back pain has no worse outcomes than bed rest, and if people with back pain keep moving, they might avoid other problems related to being sedentary during their acute pain phase," Osmick says.

The program helps members understand that they will not hurt themselves by remaining active with muscular low back pain, she adds.

Here's how the program works:

CIGNA examines its monthly claims review, looking for members with several episodes of low back pain in a 12-month period of time. Members with more serious causes of low back pain, such as those with spinal tumors, are excluded.

Members also may be enrolled in the program by self-referral or referrals from physicians, case managers, or nurses in other disease management programs.

"It frequently happens that a member is being treated for diabetes or another condition and their problem with back pain comes to light in conversations with the disease management nurse," Osmick says.

When members are identified as eligible for the program, a disease management nurse conducts a telephone assessment, looking for red flags that indicate more serious low back problems.

For instance, if someone with chronic low back pain has loss of bladder control, numbness, loss of feeling, loss of muscle strength, or fever, he or she isn't appropriate for the low back program.

Instead, they should see a physician immediately, since these symptoms might mean a more serious problem is occurring, Osmick adds.

"Patients with these symptoms in addition to low back pain are directed to see a physician immediately to define the cause of what may be a potentially serious problem," she says.

The nurses ask questions about how severely back pain limits their activity, how much time they have missed from work, and factors such as smoking, being overweight, and a history of back surgery.

"We put together a snapshot of the member. We are looking for someone who has a type of low back pain that is amenable to self-management and prevention," she says.

The initial nurse assessment stratifies members into severity levels. The severity level dictates a minimum number of calls the nurse makes to the patient.

The nurses find out how much knowledge the members have about low back pain, whether they know how to work ergonomically, and help them try to discover what they may do in the course of everyday life to exacerbate the problem, she adds.

"This program helps them understand the physical mechanics of why they got into trouble," Osmick says.

If the patient does not seem to be progressing well or has problems with reinjury, the nurse may increase the frequency of calls with the member. If the member develops any of the "red-flag" symptoms, the nurse directs him or her to the physician. In some cases, with member approval, the nurse contacts the physician directly.

"We use nurses because of their ability to use their clinical acumen and pay attention to signs that the patient may need more attention," Osmick says.

The nurses schedule a convenient time of day for the member to receive telephone calls.

"It may be at 9 p.m., if that's what the member wants. We want to talk to people at a time when they are most likely to absorb the information," she says.

Because people who have chronic pain have a high incidence of depression, the back pain program nurses use a simple screening tool to find out if the member is likely to have depression.

"Data suggest that it costs three times as much to treat people with low back pain who are also depressed," Osmick says.

If the screening tool indicates a potential for depression, the nurse asks the member if they may share the information with their physician.

"This is a very important step in order to protect patient confidentiality," Osmick says.

In most cases, the members are willing to share the information with their physician.

As a follow-up to a positive depression screen, each time a nurse calls, she asks patients how they are doing from a psychosocial standpoint, and determines whether they are worse and if they still screen positive for depression.

"Tracking a member's depression and working with them to address these issues with their health care provider is a very important part of caring for all chronic disease problems, including muscular low back pain," she adds.

The low back pain program includes supportive material such as ergonomic guides, a diary that allows patients to track their back pain, and educational materials.

The nurses instruct members on issues such as smoking cessation, strengthening exercises, positioning exercises, and how the way they sleep at night can affect their backs.

"There are many things that increase back pain that people don't think about. We help them understand what may be causing their problems and how to correct it," she says.

When members have been in the program for 12 months and are stable at the lowest level of severity, they can graduate from the program. If problems recur, they can re-enroll in the program. ■

Plan identifies, plugs gaps in DM programs

Pilot project focuses on severely ill

At Oxford Health Plans based in Trumbull, CT, 3% of its members account for half of the plan's medical costs.

The plan, which covers 1.6 million people in New York, Connecticut, and New Jersey, launched an initiative to identify barriers to care and close the gaps in care for its most severely ill members.

"Having a very focused and comprehensive strategy around these high-cost members can really pay off by improving quality of life, clinical quality, and ultimately financial performance," says **Alan Muney,** MD, MHA, executive vice president and chief medical officer for Oxford.

When Oxford analyzed data for its most

Incentives help sicker patients get the kind of care they need

Plan collaborates with physicians

When Trumbull, CT-based Oxford Health Plans set out to improve care for its sickest members with diabetes and congestive heart failure, it collaborated with primary care physicians and specialists to come up with a plan of care.

"We chose a very collaborative approach by involving the specialists in those areas of care in focus groups and holding focus groups for our primary care physicians to assess whether our intervention strategies were going to be acceptable to both sets of doctors," says **Alan Muney,** MD, MHA, executive vice president and chief medical officer for Oxford.

The health plan created a best practice network of physicians to treat the sickest patients with both diagnoses.

"We decided that the sickest members in both diabetes and congestive heart failure should see a specialist at least once a year and have a care plan that is sent back to the primary care physician," he says.

The plan began to track when the primary care physician did not appear to be following guidelines and created a set of member interventions to deal with issues of noncompliance.

A financial incentive plan that rewards specialists who treat the sickest patients is at the center of the program.

"These patients are sicker for a variety of reasons and we're asking specialists to take care of them, so we reward them financially, beyond what they would get for a regular visit, for taking the extra time to care for these patients," Muney said.

The plan identified a subset of specialists it determined would be best for the sickest patients to see. For instance, physicians who complete the National Committee for Quality Assurance self-certification for diabetes care were chosen to treat the diabetes patients.

There is no self-certification program for congestive heart failure. In that case, the health plan aligned with cardiologists from a major academic medical center to create indicators that Oxford can use to assess who is practicing appropriately and using the best set of prescribing patterns.

The disease management staff work closely with the members' primary care physicians to keep them in the loop.

"We know the relationship between members and their primary care physicians, and we work within that sensitivity," he says.

When a patient isn't compliant, an Oxford representative approaches the primary care physician and asks him or her to work with the health plan to help get the member back into better control of his or her condition.

When Oxford identifies the targets for the disease management program — the people who have the highest risk of generating the most cost — the case managers first identify whether they've seen a specialist.

"We engage the primary care physician with the data and get their permission to interact with the members," Muney says.

When the case managers talk to the members, they support the primary care physician's treatment plan. They tell the members that they had discussed the member with the doctor and that the doctor wants to make sure they see a specialist. The plan tracks the results, such as lab test results and number of hospital and emergency department visits.

The plan's physicians often have one-to-one conversations with the primary care physicians.

"The goal is to have the end results roll up into a definite improvement in the bottom line in terms of the total cost of care and doing the right thing for the member," Muney says. ■

severely ill members with congestive heart failure and diabetes, the results were surprising.

"When we looked at the data around our sickest members, we were fairly stunned at what we found," Muney says. "Of the patients who were the sickest by our definition, only a third had seen a specialist in the past 12 months."

For instance, among the sickest of the congestive heart failure patients, those who by Oxford's definition needed an electronic scale in their homes, approximately two-thirds had not seen a cardiologist in more than a year.

Among diabetes patients, two-thirds of members with a hemoglobin A_{1c} greater than 9.5% and a significant number with levels above 11% had not seen an endocrinologist in a year.

That's why Oxford has chosen to change courses and look at what problems prevent optimum performance in their case management and disease management programs.

"The health plan has to look at barriers to optimum care, including whether the member is being treated by the right physician, whether the member is compliant — an issue that occurs even when case managers call them regularly — and what prevents members from following up with what the doctors

Gaps in accountability impede DM success

Noncompliance, lack of social support are issues

Identifying the gaps in care and accountability and closing those gaps is the key to a successful disease management program, says **Alan Muney,** MD, MHA, executive vice president and chief medical officer for Oxford Health Plans in Trumbull, CT.

Nobody questions the value of case management programs in helping people better manage their illness from a quality performance or clinical outcome standpoint, Muney says.

However, he contends that gaps in the program are largely responsible for the difficulty health plans have in proving the financial value of case management and disease management programs.

Most health plans do well in the area of case management intervention, Muney says.

But there are gaps when it comes to making sure the sickest members are being cared for by the correct physician, which means a physicians who has the highest performance of treating people with that particular illness, he says.

When Oxford took a close look at barriers to optimal treatment for its members, the plan identified a number of barriers to care.

One gap is in the accountability measures in the system — identifying who is responsible when a member isn't compliant or doesn't get better, Muney says.

He cites physician noncompliance with guidelines and poor communication among all parties involved in the member's care as other gaps in accountability.

For example, a primary care physician refers a patient to a specialist, who treats the patient, but then each physician believes the other one is following up. "The member doesn't understand what the follow up is supposed to be and, as a result, nothing has happened," he says.

Social issues, such as support for the family or caregiver and assistance with issues such as transportation, also contribute to the accountability gap, Muney says. "We looked at these barriers and decided that we need to have control in our health plan to plug the gaps in accountability."

Oxford has had disease management programs for about nine years.

"We have been doing what most other health plans have done, and that is focus on the strategy of the nurse case manager intervening with the people we defined as the sickest in that disease state," Muney says.

The company has been working to identify the right severity of illness within each disease state where they can make a difference in managing costs.

The health plan's new focus is to work closely with the sickest patients, those who account for the biggest health care cost, and identify each individual's barriers to care. **(For details on how the program works, see related article on p. 77.)**

Oxford has approximately 14,000 members in its congestive heart failure program. Of those, 1,200 are designated as the sickest patients. There are 35,000 members identified with diabetes, with 3,400 in the highest-risk category.

"These 4,000 or so members are pretty manageable in terms of case manager interventions, and they are by far driving most of the cost within the disease," Muney says. ■

told them they should do," Muney points out.

The company began to look deeper at what was going on at the primary care level and found that both physician noncompliance with guidelines and member noncompliance with the treatment plan were barriers to care.

"The primary care physicians would tell patients to take certain steps, but the patient would ignore the doctor's advice. But we also noticed that the primary care physician didn't request certain tests or put some patients on what we viewed as the correct drug," he says.

An evidence-based medicine approach to the total cost of care is the key to Oxford's new overarching disease management program.

"This means everybody should get everything they need, but not services that they don't need. We are looking for gaps in accountability plus trend-driven costs and evaluation," Muney says.

The company took a hard look at the cost drivers that affect the total cost of managing chronic disease.

"We wanted to determine whether high-cost procedures and other interventions were delivering the best value. We look at disease management as the sum of three major components: case manager interventions; accountability gaps, such as physician and member noncompliance; and major trend drivers within the disease," Muney says.

The company focuses on unit cost and utilization compared to guidelines to help them understand whether care is effective, he adds.

Oxford launched a pilot project a few months ago to treat the 250 sickest members in the congestive heart failure program and the 250 sickest in the diabetes program.

Before starting the pilot project, the company developed a network of specialists who are willing to take sicker members with more complications. **(For details on how the health plan works with physicians, see p. 78.)**

"Our disease management program includes not just case management interventions but identifying which are the best physicians to deal with the illness, how they perform, and what are the trend drivers within the disease in terms of procedures and services. The net result, we believe, is higher quality care as well as lower cost," Muney says.

The plan starts by identifying the highest-cost members and those who are anticipated to have the highest cost by using a predictive modeling software tool.

Endocrinologists taking care of diabetes patients are encouraged to self-certify with the National Committee for Quality Assurance program. Oxford also worked with leading endocrinologists and cardiologists. The cardiologists helped craft a best practices in congestive heart failure program.

When members are enrolled in the program, the case managers make sure they have seen a specialist. Then they drill down to find out which individuals need more interventions in one component or another.

The interventions are tailored to what is going on with each individual member.

"To some degree, basic interventions, such as lab tests and doctor visits, need to occur every so often, but a major component is a highly focused member approach," Muney says.

For instance, members with congestive heart failure are given an electronic scale and instructed to weigh themselves once a day. The results are transmitted to the case manager, who looks at the weight and decides if an intervention is warranted.

If the weight is in the pre-determined "red zone," the case manager contacts the primary care physician and the member.

What happens then is individualized to the physician's preference and what is needed for the member, with the goal of following well-accepted practice guidelines.

Often, the primary care physician has standing orders for the member, depending on the member's condition. In this case, the nurse may call in the standing order or the physician may prefer that the member call the office for further instructions.

"The important thing is that the intervention occurs where there is weight gain that can trigger an emergency room visit, or a hospitalization and all the complications that follow," he says. ■

Concentrate on those who will benefit the most

HMO moves to reduce cost of health care

By concentrating its disease management efforts on members who are likely to benefit most, an Indianapolis-based HMO hopes to keep its members healthier and reduce costs to employer groups at the same time.

"The bottom line is that health care costs are going up at a rate that our country cannot afford. Employers are very upset about it and are looking for ways to reduce costs. Many are considering reducing benefits, and that may be counterproductive in the long run," says **John C. Ellis**, MD, FAAP, associate medical director for M-Plan, Indiana's largest commercial HMO.

"As an HMO, we believe that our members should have access to preventative care, and we do everything we can to keep everybody healthy. This will lower the costs for members and employers and improve health care overall," he says.

The plan is working with a number of different tools, some from outside vendors and some developed internally, to identify the members who are likely to benefit most from disease management interventions, the kind of information likely to work best in helping the members control their diseases, and what initiatives are most easily put into action.

Identifying high-cost patients

In addition to concentrating on members who already are experiencing high costs, the tools identify patients who are not high health care users but are likely to become so in the next 12 months as indicated by prior utilization patterns and other indicators.

These may be people who refill their prescriptions only half the time or those who have diseases that are likely to get worse with age.

"The bottom line is that we want to identify members who have a chronic disease or are at risk for developing a chronic disease and make sure they are getting the best care they can get and are as healthy as they can be," Ellis says.

The health plan chose to concentrate on the top 3% of members because they have the resources to handle that many members.

The vendors give M-Plan information in a

database form easily accessible by nurse case managers. The members are prioritized by severity, and information on their specific issues is included.

"The more usable information you have, the better you are able to care for members and their health. If members are paying for their health care through payroll deductions and the employers are paying a lot for it, they're also interested. We consider ourselves to be the steward of our members' dollars," he adds.

An advisor group of physicians helped M-Plan design the way to approach members with chronic diseases.

Stratifying into severity groups

Once the members are identified, the plan stratifies them into severity groups. The interventions depend on the members' severity.

"We make a lot of information available to members. Some take our advice and some don't. For instance, we offer smoking cessation for members with asthma, heart disease, diabetes, and other conditions because smoking makes the risk substantially higher. Some are interested and some are not," he says.

M-plan makes an effort to identify the members who are interested in smoking cessation and intervene with them.

"If they are interested, we want to help them do what they need to do to be successful. Because we are stewards of the members' premium dollars, we try not to have a big program for those who aren't interested in stopping," he adds. M-Plan concentrates on providing resources where they will have an effect, Ellis says.

For instance, the plan offers smoking cessation programs to members with chronic diseases.

"We look at ways to provide them opportunities to take advantage of the entire program or just parts of it. For instance, if they may be thinking of stopping eventually, we may send them a mailing every month. If they are serious about quitting, we may have someone call them," he adds.

If they are not thinking about quitting and not willing to think about it, the health plan provides them some information about smoking and its effect on their chronic disease.

"We try to provide appropriate information for the members who don't want to stop smoking to make sure they are aware of the opportunity in hopes that it may move them along the path," Ellis says.

"It's a real challenge. Some people don't want to be bothered at all about their smoking. We have to be very careful how we do it," he says.

The health plan has used pharmacy claims data to identify members who are taking antidepression medication and contacts them to encourage them to comply with whatever they and their physician have decided to do, Ellis says. The plan monitors their prescription refills and if member don't refill them, they get a telephone message reminding them that the medication should be refilled unless the physician and the member decided not to continue it.

The messages are provided by a vendor who carefully scripts them to meet the members' needs.

"We started with reminders for physician appointments and have branched out to send other kinds of messages to our members," Ellis says. The recorded messages have been very well received, he adds. "We have sent tens of thousands of messages about depression and have had only a few complaints."

M-Plan has provided its network participants with very specific unique profiles that the health plan designed, Ellis says.

"We have a variety of methods to make sure all our physicians are aware of the guidelines, and down the road we hope to be able to monitor more carefully how physicians are complying with the guidelines," he says.

The plan gives physicians information about their practice patterns that are risk-adjusted.

"That way, if somebody writes more prescriptions than somebody else, they can't necessarily claim their patients are sicker because that is factored in," he says.

M-Plan takes steps to make sure that physicians are aware of treatment guidelines and that the members are aware of what they should be doing.

"Overall, patients with asthma across the country are underdiagnosed, and the level of severity is estimated regularly. They aren't treated as aggressively as they should be," Ellis says. ■

GUEST COLUMN

Correcting medical errors: How far do you go?

CMs have a responsibility to monitor errors

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The occurrence of medical errors made by health care providers against patients has been at the forefront of the media in recent years. Dealing with the occurrence and subsequent outcomes of medical errors is a hazardous part of our jobs, but it is not a new phenomenon as it may appear to health care consumers due to this vast amount of attention.

In fact, very few medical mistakes result in patient harm — that is, an outcome that results in requiring additional medical care, lost time from work or, worst case scenario, a disability or even death.

As a case manager and patient advocate, you have a moral responsibility that goes along with those roles to monitor any errors that could potentially result in harm to the patient.

In general, all health care providers have a duty to practice according to a standard of care, and when a health care provider commits an error, he or she has breached that standard of care.

Essentially, our patients have a right not to be wronged and when they suffer physical, emotional, or psychological harm due to a medical error, they not only have been harmed, but they have been wronged by the health care delivery system.

Secondly, patients have rights to make decisions about their care and to be informed as to why additional care is needed. This is where the disclosure of medical errors becomes important for case managers. If, for example, the patient requires an additional procedure to correct an error that occurred in the initial procedure, that patient has a right to know why the additional medical attention is necessary.

This scenario may take place if, for example, a surgical device was not removed after completing a surgery. If that information is withheld from the patient, he or she is not giving a valid consent to that second procedure because the patient does not truly know why the additional care is required and has, in essence, been wronged by the system.

Furthermore, because most patients who have suffered harm as a result of a medical error do require additional care, it is morally wrong to expect patients to bear the financial burden of the costs associated with the added care.

The 'silent response'

Not disclosing a medical error committed against your patient often is referred to as a "silent response," and is indeed a moral mistake. But how can you be sure if a medical error has truly occurred? They typically are uncovered while performing routine patient management tasks.

Because of the nature of our jobs, case managers are in step with the day-to-day treatments and care of our patients. Each intervention is carefully monitored, and when additional care is required, it is a natural response for a case manager to question it.

Basically, any error resulting in medical care that was not initially anticipated is a red flag and should be investigated. In fact, the Commission for Case Manager Certification (CCMC) has established a *Code of Professional Conduct for Case Managers*, which includes a section on ethics. This section mandates that if a medical error occurs during the course of a patient's treatment in which the case manager is involved, the case manager is ethically obligated to acknowledge and address such errors as a condition of his or her certification. However, this is different from reporting the incident, which may or may not be necessary, depending on the circumstances and outcomes of each individual case.

Getting to the root of the problem

Should you suspect that a potentially harm-causing error has indeed occurred, there are a

number of steps to take before confronting the patient:

• **Confirm and clarify your suspicions.** The best way to begin your research is to discuss your concerns first with the physician who is managing the patient's treatment. Simply ask, "Was this an error?"

Keep in mind that what happened may sometimes appear to be a medical error on paper, when in fact it was not and there is a good clinical explanation for the subsequent steps that are being undertaken in the patient's treatment plan. If the error occurred while the patient was hospitalized and you still are not satisfied with the responses you are receiving from the providers, talk with the internal case manager and perhaps the hospital's risk manager about the case.

Should you discover that a patient was harmed due to a medical error, but those involved have decided not to disclose the information, as a patient advocate, you should attempt to persuade the providers to reveal the information. Should that effort fail, your last resort is the ethics committee of the organization.

Liability is, of course, the core reason many institutions shy away from total disclosure in some cases of medical errors, however, recent research suggests that health care facilities may in fact *lower* their overall risk of malpractice by implementing policies of full disclosure at all times.

The reason appears to be that, in cases where hospitals have come forward with full disclosures of medical errors that impacted their patients in any way — even in those cases where the patients may not have known an error occurred — the patients were less likely to bring a lawsuit against the facility.

• **Document, document, document**. Keep copies of records and document conversations with other care providers involved in the patient's treatment. This way, you will have documented evidence of the proactive steps you have taken to ensure the patient has received the best care possible and that you have worked within the parameters of your case management role to avoid any adverse outcomes as a result of the services the patient received under your care.

• **Confront the patient with compassion, but do not advise.** Regardless of the outcome of your efforts, case managers have a duty to make information available to their patients. Therefore, the final step, armed with information, is to inform the patient what happened, but not to provide advice regarding legal action or any other possible subsequent actions that may be taken in response to this information.

Those decisions should be left up to the patient and his or her family. For example, say, "Mr. Jones, what happened was this mistake. You need to know that what's charted here is you received a very high dose of this particular drug. The order was for 10 mg of oxycodone, and you received 100 mg. There is reason to believe that this might have caused all the problems that you had that week in the hospital."

Confronting medical errors can be one of our most wrenching tasks as case managers. However, errors, as in any industry, will continue to happen as well in the health care community. The trick is to keep those errors from causing harm to our patients. ■

CE instructions

Case managers and other professionals participate in this continuing education program by reading the issue, 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, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this activity each semester, you must complete the evaluation form provided and return it in the reply envelope provided in order to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

COMING IN FUTURE MONTHS

- Helping patients cope with post-traumatic stress syndrome
- Case management for patients in rural areas
- Proving return on investment for case management
- Empowering patients with information

CE questions

1. When Regence Blue Cross Blue Shield of Oregon analyzed claims data, the insurer found that ____ account for half of their spending?
A. Diabetes, congestive heart failure, stroke, and asthma
B. Heart disease, cancer, gastroenteritis, and orthopedics
C. Cardiovascular diseases, diabetes, cancer, and asthma
D. Chronic pulmonary obstructive disease, hypertension, depression, congestive heart failure.

2. According to Mary Jane Osmick, MD, of CIGNA Health Care, what percentage of people who recover from an episode of low back pain have a relapse within a year?
A. 60%
B. 50%
C. 75%
D. 45%

3. When Oxford Health Care examined barriers to optimum care for its sickest congestive heart failure and diabetes patients, it found:
A. Physician noncompliance with guidelines
B. Patient noncompliance with the treatment plan
C. Neither of the above
D. Both of the above

4. M-Plan's disease management programs include members who are high utilizers of health care services and members who can be expected to become high utilizers as indicated by utilization patterns such as not refilling their prescriptions regularly or those who have diseases that get worse with age.
A. True
B. False

5. According to the Code of Professional Conduct of the Commission for Case Manager Certification, if a medical error occurs during the course of a patient's treatment in which a case manager is involved, the case manager is ethically obligated to address and acknowledge such error. The first step the case manager should take is to:
A. Discuss your concerns with the physician managing the treatment.
B. Report the error to the institution's management.
C. Inform the patient and the family.
D. Seek the advice of your supervisor.

Answers: 1: B; 2. C; 3. D; 4. A; 5. A

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. ■

New BP guidelines establish diagnosis of pre-hypertension

Level seeks to identify at-risk individuals early

New clinical practice guidelines for the prevention, detection, and treatment of high blood pressure have been released by the National Heart, Lung, and Blood Institute (NHLBI) in Bethesda, MD. The guidelines, approved by the Coordinating Committee of the NHLBI's National High Blood Pressure Education Program, include altered blood pressure categories, featuring a new "pre-hypertension" level, which covers about 45 million adult Americans.

The guidelines also streamline steps by which doctors diagnose and treat patients and recommend the use of diuretics as part of the drug treatment plan for high blood pressure in most patients.

Here are the key aspects of the guidelines:

• **Former blood pressure definitions are changed as follows:** Normal, less than 120/less than 80 mm Hg; pre-hypertension, 120-139/80-89; Stage 1 hypertension, 140-159/90-99; Stage 2 hypertension, at or greater than 160/at or greater than 100. The previous categories were optimal, normal, high-normal, and hypertension stages 1, 2, and 3.

• **Simplified and strengthened drug treatment recommendations.** Use of diuretics, either alone or in combination, is recommended for most patients. The report says they currently are not being sufficiently used.

• **Use of additional drugs for severe hypertension or to lower blood pressure to the desired level.** According to the report, most people will need two — and at times, three or more — medications to lower blood pressure to the desired levels.

• **The recommendation that clinicians work with patients to agree on blood pressure goals and develop a treatment plan.**

The guidelines do not recommend drug therapy for those with pre-hypertension unless it is required by another condition, such as diabetes or chronic kidney disease, but it advises them to make any needed lifestyle changes. ▼

New AHRQ tool checks patient safety performance

The Agency for Healthcare Research and Quality (AHRQ) has developed a new web-based tool that can help hospitals enhance their patient safety performance by quickly detecting potential medical errors in patients who have undergone medical or surgical care. Hospitals then investigate to determine whether the problems detected were caused by potentially preventable medical errors or have some other explanations.

"The first step in reducing the nation's toll of medical errors is to identify when they occur and why, and then develop strategies to improve patient safety. This goal is central to efforts to combat this problem," said Health and Human Services Secretary **Tommy Thompson**, who announced the AHRQ Patient Safety Indicators at the recent National Patient Safety Foundation Fifth Annual Congress in Washington, DC.

The Patient Safety Indicators at www.qualityindicators.ahrq.gov, are part of a major AHRQ program to improve the safety of patients in hospitals,

outpatient care, and other medical settings. The program also includes research to develop ways to prevent medical errors and a web-based medical journal that showcases patient safety lessons drawn from actual cases of medical errors.

The Patient Safety Indicators tool contains a set of measures that use secondary diagnosis codes to detect 26 types of adverse events, such as complications of anesthesia, blood clots in the legs or lungs following surgery, fracture following surgery, and four types of birth-related injuries.

Although the indicators were developed primarily for hospitals to use in their quality improvement programs, other kinds of organizations will find the tool useful.

The tool can be downloaded free of charge from AHRQ's web site, but it requires the use of SAS or SPSS software, which are commercially available statistical programs. For technical questions on the content and use of the Patient Safety Indicators, please contact AHRQ at support@qualityindicators.ahrq.gov. ▼

IOM seeks improved training to improve quality of care

Changes are needed in the education of physicians, nurses, and other health professionals to improve patient safety and quality of care, according to a new report by the Institute of Medicine (IOM) in Washington, DC.

For example, the IOM says licensing boards should require physicians, nurses, and other health workers to demonstrate their clinical skills and understanding of medical advances, rather than let the professionals simply take a class and pay a fee to renew a license.

According to the report, "five core competencies" should be adopted for programs that train health professionals: the abilities to deliver patient-centered care, to work as a member of an interdisciplinary team, to engage in evidence-based practice, to apply quality improvement approaches, and to use information technology.

In addition, the report, *Health Professions Education: A Bridge to Quality*, says licensing and accreditation organizations should ensure that students and working professionals develop and maintain proficiency in these areas.

Patient-centered care involves identifying and respecting patients' differences, values, and preferences, and includes relief of pain and suffering, the report said. For quality improvement, health professionals should identify hazards and errors, measure the quality of care, and test interventions to change processes and systems that improve quality. The fifth core element, in the area of "informatics," involves the use of information technology to mitigate errors and manage knowledge, according to the report. ▼

JCAHO revises scoring for one of its patient safety goals

The Joint Commission on Accreditation of Healthcare Organizations has changed how it scores organizations on its National Patient Safety Goal to eliminate wrong-site, wrong-patient, wrong-procedure surgery. The goal includes a recommendation that organizations implement a process to mark the surgical site and involve the patient in the marking process.

JCAHO said it will continue to require organizations to mark surgical sites involving right/left distinction, multiple structures (such as fingers and toes), or levels (such as the spine) to comply with the recommendation. However, it will no longer require the surgical site to be marked for other types of procedures, including midline sternotomies for open-heart surgery, cesareans, laparotomy and laparoscopy, and interventional procedures for which the site of insertion is not predetermined, such as cardiac catheterization procedures. JCAHO plans to provide details on the change soon at its web site, www.jcaho.org. Click on "National Patient Safety Goals & FAQs." ■

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

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