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Rural case managers give health plan a local presence

CMs succeed with creativity, understanding

When a case manager for Presbyterian Health Plan couldn't get in touch with a family with two young children with serious health problems, she packed a lunch, charged up her cell phone, drove to the small New Mexico town on the Mexican border where she thought the family lived, and went door-to-door looking for them.

Her perseverance paid off. She found the family and was able to make a home visit to ensure that the children's mother was following the plan of care and the children were doing well.

Presbyterian Health Plan, with headquarters in Albuquerque, has 10 rural case managers who live throughout the state and serve the health plan's members in rural areas.

"Most of New Mexico is rural. Because we have a statewide presence, we cover a lot of sparsely populated areas," says **Jean Calhoun**, BSN, MSN, clinical director for the case management program.

Presbyterian Health Plan (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 their members live in rural areas with few health care resources.

The state's population is 30% Hispanic, and more than 60% of them are served by PHP's Salud Medicaid program.

There is a scattered Native American population, many of whom are served by Indian Health Services. About 2% of the Native American population is enrolled in Presbyterian Salud.

The rural case managers handle everything the health plan covers except transplants. That highly specialized area is handled from the Albuquerque headquarters.

They manage members with high-risk chronic diseases, as well as adults and children with special health care needs. They have been cross-trained to provide disease case management for members in their area with asthma or diabetes.

The case managers are divided along population lines and are assigned by geographic regions.

"We watch the caseloads carefully; and if they seem to be getting high, we quiz them about whether they need to close cases or whether there's been an influx of need in the area. If so, we adjust the caseload," Calhoun says.

When PHP was recruiting nurses for its rural case management program, the plan advertised strictly in the local newspaper in the areas it wanted to serve.

The plan's goal was to hire case managers who live in the region, are familiar with the local people, and know how to approach the members.

"An effective case manager in rural areas is someone who understand the local flavor and customs of the area. Some towns are on the international or state borders and people fade in and out on a frequent basis. If they don't want to be found, they can disappear," says **Paula Casey**, BSN, MSN, senior clinical project coordinator for case management.

Rural people, particularly those who live in poverty, are wary of people from the city and have the impression that urban dwellers tend to look down on them.

"If a member is contacted by someone down the road, they feel more comfortable, and feel like the case manager is on their level and isn't coming from the big city," Casey adds.

The nurse case managers know the providers, the people in the community, and the health care and social resources in the area. They know the members by first name and often meet them in the grocery store, Calhoun says.

In fact, some members are so comfortable with the case managers that they have to be reminded not to talk about their health problems in a public place, she adds.

In many areas, case managers have to get very creative to reach their clients, particularly for the first evaluation. Many don't have telephones, running water, or electricity, Casey points out.

"The members in our Medicaid HMO program are a nomadic group. They may have a telephone today and no telephone tomorrow. Some move back and forth across the Mexican border," Casey says.

To locate their clients in the far-flung rural areas, the case managers start with the primary care physician's office, hoping to find an address or phone number.

If the person doesn't have a telephone, the case manager sends him or her a letter. In some cases, they choose to send a registered letter to make sure it gets delivered. The registered letters get good results, but it's expensive if the case managers have to send a lot of them, Calhoun points out.

"We have good success sending out a letter saying that we have been trying to reach them and asking them to call to talk to the case manager about their health," Casey says.

Most of the members have a neighbor whose telephone they can borrow. Before the Health Insurance Portability and Accountability Act (HIPAA) went into effect, some case managers would post notes for the member in the general store on the Indian reservation.

"Now, because of patient confidentiality

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Editorial Questions

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

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Safety, isolation are drawbacks for rural CMs

Quarterly inservices make them part of the team

Case managers who live and work in rural areas often face challenges their big-city counterparts never encounter.

Safety is one drawback to having a case manager who lives in the local community and knows and is known by everyone, says **Paula Casey**, BSN, MSN, senior clinical project coordinator for case management at Presbyterian Health Plan (PHP) with headquarters in Albuquerque, NM.

"The good part is that everybody knows the case manager is in town. The bad part is also that they know the case manager is in town," she says.

Sometimes members who are angry with the plan or have behavioral health issues make harassing telephone calls to the case managers at all hours of the day and night.

This has prompted the case managers to be careful not to give out their last names so the members can't look them up in the telephone book and call their home number or show up on their doorsteps.

"We have to be really careful. We want a local presence, but at the same time we have to protect the safety and privacy of the case managers," adds **Jean Calhoun**, BSN, MSN, clinical director for case management program.

Isolation is another problem the rural case managers encounter. Unlike the Albuquerque staff, they work alone, without the advantage of colleagues with whom they can collaborate.

They've overcome it by bonding as a regional team, often calling each other to bounce ideas off each other and problem-solve together.

The health plan brings them into Albuquerque once a quarter for a two-day inservice program. The session includes training that results in continuing education units and updates on what's going on in the plan.

Calhoun and Casey also hold focus groups with the rural case managers to find out how the health plan can better serve the members and make it easier for the rural case managers to do their job.

The plan started out with monthly meetings, then switched to quarterly meetings, partly because of the cost of transportation, hotel, and food. Monthly meetings were also time-consuming and took up most of a week, leaving the case managers only three full weeks out of the month to work with their clients, Casey says.

"We negotiated with management to continue the meetings because they have really been important to the staff. These case managers feel isolated, and we feel like we need to connect to them so they'll feel like they're part of the team," she says.

PHP has a workshop every year on cultural sensitivity at a time when the regional case managers are in town.

The plan advertised in local newspapers for nurse case managers when they started their rural coverage. Since then, it's been word of mouth.

"It's an excellent job for a nurse who wants to work from her home," Calhoun says.

The case managers do have to be self-directed and accountable.

"We haven't had trouble finding them, and productivity has not been an issue," she adds.

The case managers work in home-based offices, partially funded by the health plan. They use their home offices for telephone calls and paperwork but spend a lot of their time in the community, meeting with the members.

Because of the difficulty in contacting their clients by telephone, they often meet them at the physician's office and do a follow-up evaluation.

They set up periodic time for durable medical equipment (DME) vendors to come to the area and evaluate members who need wheelchairs or other DME.

Since most DME companies are based in the city, the case managers set up periodic DME evaluation clinics to meet the local needs. They rent churches or hotel rooms and hold a daylong clinic for their clients.

The case managers attend annual provider focus groups, town hall meetings hosted by PHP in the regional areas, provider meetings, and children's clinics — anything where the plan is expected to have a presence. ■

mandated by HIPAA, that may be a challenge," Calhoun points out.

When case managers leave telephone messages, they say it's a courtesy call from the health plan and leave a telephone number.

With the Hispanic population, they avoid saying the call is from Salud because many people don't want it publicized that their family receives Medicaid benefits.

The case managers often use their creativity in meeting the needs of the members. They often encounter challenges not faced by their counterparts in the city.

For instance, when the health plan made its Y2K preparations, generator and backup generator were on the list of purchases for children at home on ventilators.

In another instance, one young girl with cerebral palsy was unable to manipulate her electric wheelchair over the bumpy dirt roads and the

pastures on the Navajo reservation where she lived. Her family were sheepherders, and the young girl wanted to be able to help with the family's sheep.

The case manager was able to get her wheelchair modified with wider wheels that would allow her to go over rough terrain and help with the family's sheep.

The local television news did a story about the girl and her new wheelchair.

"Just the smile on that little girl's face as she helped herd sheep in her wheelchair was worth all the effort. Meeting the needs of people in rural areas is what we're all about," Calhoun says. ■

Check for mental illnesses that can impede recovery

Psychiatric problems are frequent comorbidities

Case managers are the center of the universe when it comes to spotting psychiatric problems that can impede recovery and return to work, asserts **Barton Margoshes**, MD, chief medical officer for CIGNA Group Insurance, based in Bloomfield, CT.

"The case manager is the only person who can coordinate the information among the doctor, the patient, and the employer. Nobody else makes contact with all three," he says.

Case managers can get subtle and not-so-subtle information from all three parties involved in return-to-work disability cases and put together a comprehensive picture of what's going on.

Many times, the physician may not have an understanding about what's going on in the workplace or the patient's life at home. He or she is looking only at the back pain or other condition, Margoshes adds.

"The worst thing that can happen is that a patient is being treated for low back pain and the orthopedist knows nothing about what is going on at work. Our case managers play a pivotal role in making sure we uncover the hidden issues," he says.

Case managers are at the forefront of CIGNA's holistic approach to managing the care of members covered by group disability insurance, Margoshes says.

The CIGNA group disability insurance program is separate from the plan's workers' compensation program and is for people who do not get hurt on the job but suffer the same kinds of injuries and illnesses and face the same return-to-work issues.

"We take a holistic approach, looking for not only a psychiatric condition but also another medical condition that could impede return to work," he says.

Psychiatric problems are very common among people with disabilities, Margoshes says.

He cites statistics published in *Managed Behavioral Health News* that 65% of people with disabilities have multiple impairments and 40% have a behavioral health comorbidity.

"If you look at them through blinders without determining if there are other things going on, you're going to miss something. That's why we use our holistic approach, as opposed to the impairment approach, and perform a comprehensive evaluation of the individual," Margoshes says.

Screening for factors that can impede recovery is an integral part of any case management activity, Margoshes says.

"These kinds of things are not always evident, but if someone is having a difficulty with treatment or return to work, it can mean that post-traumatic stress disorder (PTSD) or another psychiatric or medical condition is unrecognized," he says.

For example the first six months following the terrorist attacks of Sept. 11, 2001, CIGNA experienced a 7% increase in psychiatric disability claims.

Many of the claims were for PTSD or a severe, long-lasting reaction to a stressful event.

The increase in cases was just a temporary bubble, but it created a greater awareness of psychiatric disabilities, their effect on the workplace, and the need for early treatment, according to Margoshes.

Now, as members of the armed services reserves return from active duty on Afghanistan and Iraq and go back to work, it is possible that PTSD cases may crop up, he says.

"It may present as a physical problem but in fact, they may also have a psychiatric condition," Margoshes says.

PTSD can be a single diagnosis that causes a disability or an unrecognized comorbidity that complicates another diagnoses, Margoshes says.

PTSD can occur in the workplace. That's what happened Sept. 11.

Return to work helps recovery for the disabled

Re-establishing normal life is important

Being at work and re-establishing a normal life rhythm is an important part of a successful return to work after someone is disabled.

That's why CIGNA's case managers do everything they can to get their patients back into their normal lives before the illness or injury, says **Barton Margoshes**, MD, chief medical officer for CIGNA Group Insurance in Bloomfield, CT.

"We try to get them back to as normal a life as they can have. Return to work is a very important part of the treatment strategy," he says. "The real tragedy is when the other problems, such as psychiatric disorders, are not recognized and people aren't able to return to work."

It's important for anyone with post-traumatic stress disorder (PTSD) or any other psychiatric condition to maintain a productive working life, he adds.

"When someone is disabled and can return to work and doesn't, there are profound consequences. It's bad for the individual, bad for the employer, and bad for society in general," he adds.

Case managers, who make frequent contact with patients who are on disability, are in a good position to make sure the patient gets what he or she needs for a successful return to work.

What happens once the case manager picks up on the cues that a psychiatric problem may be exacerbating the physical problem varies from person to person.

The case manager may reach out to the treating physician and tell him or her something else is going on. If the person is having concentration problems or seems agitated at work, the case manager may suggest that he or she see a mental health professional.

The case manager may suggest that the person use some of his or her resources at work, such as employee assistance programs (EAPs).

EAP counselors are trained to pick up cues as to what is going on and make the appropriate referrals, Margoshes adds.

"Our case managers' role is to identify something that may not be readily apparent and make appropriate referrals to the EAP or discuss with the treating physician that the person needs additional help," he says.

Sometimes the case manager works with the employers on a workplace accommodation, such as having the member gradually reintroduced to work, starting off part time and working up to full time.

The case managers are careful to maintain confidentiality with their group disability clients. When the case managers call the employer, they don't give out any medical information about the patient's condition or any underlying problems they are having. They tell the client's supervisor that they're working with them and ask if there are any issues at work that may be confounding the situation.

They talk to the employers about adjusting the hours so the employee is gradually reintroduced to work and suggest other workplace accommodations.

If the member is having problems with concentration, the case manager works with the company to give him or her another job that doesn't require the same level of concentration. If the problems are largely with communication, the case manager may recommend a temporary job shift.

If the employer has an on-site EAP, the case managers try to steer the member to a job coach, someone to talk to when things aren't going well.

"If they're having problems at work, the can leave, which is not necessarily the best outcome, or they can call up the EAP which helps them work through the issues," he says.

With PTSD, people experience a lot of anxiety. If a worker is feeling anxious, he or she can call the EAP and get help working through it. ■

Someone who is a victim of a violent crime or something less dramatic also can suffer from the condition.

It's common for people who have PTSD to have problems at work. They may be having problems concentrating. Their productivity and quality of work suffers. For the first time in their lives, they may get a bad appraisal. Their employer reports interpersonal conflicts with co-workers.

"The case manager looks for clues as to whether something else is going on and that this individual needs help," Margoshes says.

At CIGNA, the claims case managers and nurse case managers work together. The insurer's psychiatrists and other medical directors consult on the more difficult cases.

"There is a coordinated approach between our clinical team and our claims administration team," Margoshes says.

The case managers do a quick screen for psychological issues on almost every group disability case.

"Our case managers don't just look at an individual based on diagnosis alone. We probe and

search for other things going on in their lives that may affect their recovery.

They find out a lot from talking to the patient, asking if they are having any problems at work," Margoshes says.

For instance, someone may be on disability because of low back pain but may also have PTSD or another psychiatric condition that delays recovery and return to work.

"The most important part of helping someone with a psychiatric disorder is early intervention and identification," Margoshes says.

Identifying disorders

There are two ways to identify patients with psychological disorders: The easy way is if they already have a diagnosis and are in treatment. In this case, the nurse case manager works with the patient, physician, and employer on return-to-work issues**.**

In the more difficult cases, the psychiatric disease is not readily apparent but the case manager picks up cues that the patient has more than just physical problems.

Most conditions have a "predictable recovery trajectory," Margoshes says.

The case managers have a good idea how a patient's recovery should go and when he or she should be able to return to work.

When the patient isn't improving with appropriate treatment or is getting worse, the case manager probes to find out what other issues could be causing the problems.

Another clue that something else is impeding recovery is if the diagnosis keeps changing. Maybe the patient first complained of back pain, then switches to neck pain or pain in some other area.

"Maybe something was missed on the diagnosis or maybe the doctor was not aware that something else was going on in the person's life," Margoshes suggests.

For an example, a member has a primary diagnosis of low back pain and doesn't seem to be recovering. The case manager looks for other issues that may affect recovery, speaking to the employer, the physician, and the patient.

"When we get cues that this person may be having workplace difficulties or family issues or financial issues, these are a red flag that maybe something else is going on," Margoshes says.

Throughout the course of the disability, the case managers maintain contact with the member on a regular basis. ■

Include DM when you work with patients

Comorbidities can negatively affect recovery

Even if you're not a designated disease management case manager, you can help your clients manage their chronic diseases, according to **Carole M. Stolte-Upman**, RN, MA, CCM, CRC, CDMS, CPC, director of Chesapeake Disability Management Inc., a disability case management company in Towson, MD.

"It's all a part of the case management concept of taking care of the entire person and not just the broken leg. Case managers can fill the role of being the eyes and ears of a disease management program when they are on-site. They can augment the telephonic component of disease case management," she says.

Case managers are in an excellent position to identify patients who have underlying comorbidities that can impede their recovery and to educate these patients about their condition and how to manage it, Stolte-Upman adds.

"Because one question leads to another question, case managers can sometimes stem the course of the disease by picking up cues and asking the next question that would lead to better management of that disease," she says.

For instance, if an organization has a cardiac disease management program and is following an individual by telephone, an on-site assessment may be needed. Case managers are in an excellent position to provide that kind of information, she adds.

At Stolte-Upman's organization, 95% of the case management practice is workers' compensation. Although the case managers are not specifically targeting chronic diseases, they often work disease management education into their case management initiatives, she reports.

"When we manage long-term disability clients, we are always attuned to the fact that there may be underlying diseases that negatively impact the course of care," Stolte-Upman says.

For instance, in the case of an injured worker, an underlying problem such as diabetes can impact the healing.

"They often have a lack of understanding of their disease. They have failed to go to their primary care physician for regular checkups and haven't complied with the plan of care. Our case

managers are out there front-and-center and are in a good position to offer the education component to help the worker keep the chronic disease under control," Stolte-Upman says.

She once handled the care for a patient with hypertension who passed out and fell off a roof.

The client said he had been told he had "bad blood," but added that he would know if he really had a problem and he knew very little about his disease.

"This is another example of how on-site case managers can collaborate with disease managers by identifying the level of knowledge, helping the patient avoid potential secondary complications, and getting the patient into an early treatment program," Stolte-Upman adds.

Case managers who encounter people with chronic diseases should make sure that the individual is hooked up with the appropriate medical care.

If the patient isn't covered by insurance, case managers can plug them into free or sliding-scale management programs in clinics or can work with the primary care physician to put them into a medication program or drug study program, she adds.

Stolte-Upman estimates that at least half of the workers' compensation patients she manages have some kind of underlying comorbidity. Arthritis, lupus, hypertension, diabetes, and cardiovascular disease are among the most common conditions.

"We have always seen a lot of things coexisting with industrial injuries. Our aging work force has had an opportunity to develop other health care issues, and we have an opportunity to be proactive in addressing these," she adds.

Case managers often encounter the presence of drug and alcohol problems in their clients and can take that opportunity to refer the client to a disease management program, Stolte-Upman says.

Case managers should talk with their patients with chronic disease to determine the barriers to managing the diseases.

"It may be fear, lack of knowledge, lack of financial resources, and lack of understanding. It's amazing how many people are not sophisticated health care consumers and have no idea of what the appropriate treatment is for their disease," Stolte-Upman reports.

When she assesses a new client, she looks for underlying factors that will prevent a good outcome in addition to information relevant to his or her industrial injury.

"We find out what the barriers to care are and identify the kind of care that would be accepted by the patient," Stolte-Upman says.

Case managers should always be sensitive to cultural diversity when they treat patients and have an understanding of the issues that can be an incentive or disincentive for them to follow the plan of care, depending on their cultural background.

"The nurse case manager holds the key to finding the way to address the issue in a way that the patient is comfortable with," she says.

For instance, many cultures use homeopathic and home care remedies, some of which could interfere with their treatment.

In these instances, the case manager needs to be supportive and nonjudgmental while concurrently demonstrating respect for unfamiliar belief systems, Stolte-Upman says.

"We carefully build on that respectful relationship to encourage compliance with treatment plans that will render positive outcomes," she adds. ■

How to help patients make informed decisions

'Information prescription' should be part of care

Case managers should always remember that giving patients the right information about their condition is a form of care, **Molly Mettler**, MSW, says.

"It's more than semantics. We are saying that having good information is as important as any medical test. Any care that happens without information being part of the process is incomplete care," adds Mettler, past chair of the National Council on Aging and senior vice president of Healthwise Incorporated, a Boise, ID, organization with a mission to help people make better health care decisions.

She and her company promote a concept called "information therapy," which means getting the right information to the right patient at the right time.

Patients typically forget a critical amount of information they receive during a physician visit, Mettler says.

Not only are physician visits of short duration

but often patients are stressed about their condition, not feeling well, and are given far more oral information than they can absorb.

Prevent information erosion

Dutch researchers discovered that patients forget between half and 80% of all medical information delivered during the average consultation. Their study, published in the May 2003 issue of *the Journal of the Royal Society of Medicine,* showed that if the patients were given 10 facts, they forgot five of them and remembered half of the rest incorrectly, she says.

"There is a terrible erosion of medical information in the hands of the patient. Preventing this information erosion is a significant issue for case managers," Mettler says.

She advocates "information therapy" or putting the right facts in the hands of patients and their family in a way that helps them make a decision that's right for them.

"One of the great laments of case managers and other providers is that patients get a plan of care, but they don't adhere to it or fully participate in it," she adds.

Giving a patient the right information won't necessarily assure adherence, but patients who do not get good information routinely during the health care process have a harder time complying, Mettler explains.

"The average physician consultation is seven minutes long. People who are enrolled in a case management programs often have multiple health problems, behavioral health problems, multiple prescriptions, and need to make lifestyle changes. You can take everything an average patient experiences and multiply it for patients who are in a case management situation," she says.

One of the most important things for case managers to remember is how they communicate the medical information their clients need.

"They should be making it available for their client as part of the process of care," Mettler says.

Building on the foundation of information a patient has also is part of the process of care, she says.

Case managers should find out what kind of information the patient already has in his or her hands, make sure it is the kind of information the patient needs, and supplement it with better or more detailed information if necessary.

"When the dawn of the Internet happened, everybody thought how wonderful it is that the vast medical libraries of the world were available. But it's more like a fire hose. Consumers are inundated with too much information with no quality control about it. Some of the information is OK, some is just dumb, and some is downright dangerous," Mettler says.

The best way to help your clients get the proper medical information is to give them an information prescription as part of the process of care.

"It's almost like patient safety for information. If they don't have the correct information, they may not be safe," she says.

"Information prescriptions need to be built into the process of case management in a way that doesn't add to the workload," Mettler says.

When a patient has access to a computer, the case manager and patient or caregiver go through a real-time coaching and counseling session on-line.

Mettler's company, Healthwise Incorporated, has developed an electronic tool for "information prescriptions." The Healthwise Knowledgebase is used by a number of hospitals, health insurers, and other providers.

Healthwise Incorporated offers a model of information therapy that allows case managers, physicians, and others to "prescribe" visits to a web site that includes decision guides and other information targeted to the member's particular diagnoses.

"This helps case managers save time because they have a credentialed information source they can go back to again and again," she says.

"We think that information therapy could result in better outcomes across the board. I can see it becoming a practice enhancement," she says.

The right moment

Ultimately, Mettler believes, a health plan or case management service that offers prescribed targeted information to patients will have an advantage.

"Any care that doesn't include information therapy is incomplete care," she says.

Newsletters and other printed materials may fall short because members don't get the information when they need it, Mettler points out.

"The moment they need it is when they have a decision to make or a health behavior to change, or when their illness is getting worse or getting better. The right moment when information is

needed is determined by the patient who is at a crossroads and has to change something, make a decision, or face a change in health status," she says.

Healthwise Incorporated updates its database quarterly with the latest information from medical journals, puts it in language the consumer can understand, and lays it out so it can be used in decision making.

"There are a lot of databases available, but what people want most is information that helps them make a decision about what they need to do next to help manage their health problems," she says. ■

Bedside interventions reduce admissions, stays

Plan targets disabled SSI members

As a result of case management interventions at the hospital bedside, emergency department (ED) visits, hospital admissions, and net days in the hospital have dropped dramatically for the Social Security Disability Insurance (SSI) population served by Horizon/Mercy.

The health plan, a program of Horizon Blue Cross Blue Shield of New Jersey, is New Jersey's largest managed health care organization serving the publicly insured in all 21 New Jersey counties. The company has headquarters in West Trenton.

The program was aimed at members who typically use the ED and hospital as their medical home, rather than using a primary care physician or choosing a specialist as a primary care physician.

"They were not receiving their durable medical equipment or having their prescriptions filled at the pharmacy, and they often ended up in the emergency room. Most people with chronic disease and disabilities who come to the emergency room usually can be admitted for at least 24 hours," says **Pamela Persichilli**, RNC, director of utilization management for Horizon/Mercy.

The project was designated a Best Clinical and Administrative Practice by the Center for Health Care Strategies, a Lawrenceville, NJ, organization that promotes high-quality health care strategies for low income people.

To calculate return on investment, the health plan reviews the medical history of the people who were visited by the case managers to see their resource utilization before the bedside intervention, and then compares it to utilization after the intervention.

The health plan monitored 536 members who received bedside interventions and maintained consecutive enrollment for six months before and six months after the program began.

In the first six months, ED utilization decreased by 20.11% among the 536 members who received bedside interventions, compared with the six months before the program began.

There was a 17.52% decrease in net admissions per 1,000 members and a 7.09% decrease in net days per 1,000 members among the same population.

At the same time, there was a 31% increase in members who were treated by a primary care physician and a 3% increase in members treated by a specialist; home health services increased by 336%; pharmacy costs increased by 7%.

Successful interventions

After the program started, the successful social work interventions went from a rate of about 30% to 40%-60% or above. The definition of a successful intervention is that the social worker found the member and spoke to them.

Before beginning the program, Horizon/Mercy examined claims and case management data and identified the top 20% of its SSI population that was utilizing the hospital ED for care instead of visiting a physician.

The program started out with the SSI population and state-funded General Assistance beneficiaries, mostly adult men eligible for Medicaid. Halfway through the project, the state removed the General Assistance members from the Horizon-Mercy population.

"At that time, we examined the preliminary data to determine if it was worth it to continue. The initial data demonstrated the impact of changing members from an inpatient and emergency room model to a primary care physician and specialist model," Persichilli says.

The members targeted by the program are a challenge to locate. Few members have telephones. Some change addresses frequently and many have a fear of home visits. If a social worker attempts to visit them, the family members may be afraid to open the door to a stranger.

"The members are only slightly above the poverty level. Many are homeless. It's a significant challenge to do any case management or to be able to impact their health needs when we

cannot find them," says **Philip Bonaparte**, MD, chief medical officer.

Instead of going on home visits and searching for them in the community, the Horizon-Mercy staff decided to visit the chronically ill members in the hospital.

"We're working with the member at their most vulnerable time, a time when they are in the hospital and they see firsthand what the impact can be of not following their plan of care. The case management social workers are helping them right then and there, and they are starting to build a trusting relationship," Bonaparte says.

The hospitals notify Horizon-Mercy within 24 hours of any member's admission.

"This notification has nothing to do with approving or denying care. We have a program status code that identifies what plan the member is enrolled in. It is a tickler for the social work case manager to know who she needs to visit in the hospital that day," Persichilli says.

The social worker case manager visits the members at the bedside with a cell phone and helps the member locate his or her primary care physician on the spot.

"The social work case manager can help eliminate some barriers for care. They can change the primary care physician to someone familiar to the member, or at least, in their neighborhood," Persichilli says.

They set up appointment with specialists if it's indicated and call the Horizon-Mercy case managers to introduce them to the member.

"These are some of the simplest things to do to change the behavior of our members, and it goes a long way toward increasing satisfaction," she says.

The social worker case managers help introduce families to various community services and programs, such as food stamps, housing, and assistance with utility bills, and link them with other help available through community support organizations. They identify people with a behavioral health or addiction issue who need to be plugged into support in those areas.

When the program started in November 2001, the social workers performed a 30-question assessment.

"They learned a lesson that these were far too many questions to ask at such a time," Persichilli says.

The questionnaire has since been pared down to 10 questions, which gives the health plan the information it needs but doesn't tire out the patients. ■

Partnership with providers is key to good care

Health plan reaches out to hospitals, physicians

When **Philip Bonaparte**, MD, joined Horizon Mercy as chief medical officer, his vision was for the health plan to be a partner with the local health care providers.

"Although we are a health plan, we do not provide direct health care for the members. Our role is coordination, and we can do that more effectively by forming a close working relationship with the doctors, the hospitals, and other clinicians who are touching the members and providing the care," he says.

One of his initiatives in improving health plan-provider relations was to create a dedicated hospital liaison who is dedicated to helping the hospitals decrease denial rates.

Another involved putting Horizon/Mercy case managers on-site at some of the area's largest hospitals, working with members who need complex assessment and care plans. One goal is to cut hospitalizations and emergency department (ED) usage among this population.

The on-site case managers collaborate with the hospital case managers and social workers to make sure the patients know their primary care provider and they coordinate transportation and other social needs. They work with the Horizon/Mercy members to encourage them to see a primary care physician rather than using the ED for their routine medical needs.

Negotiating to expand

Before the program was implemented, Bonaparte; **Pamela Persichilli**, RNC, the director of utilization management; the health plan's hospital liaison; and director of social case management liaison met with representatives of the case management department, social work department, and medical leadership in all the hospitals.

The hospital representatives asked a lot of questions before the program began and three of the 10 initially approached declined to participate.

"Every hospital has social workers. We did not want them to feel threatened that we were coming in to take over their job. Once they recognized that we wanted a true partnership with them,

they embraced the idea," Bonaparte says.

The project is in place at seven of the largest hospitals with which Horizon/Mercy contracts. The health plan is negotiating to expand the program to other hospitals.

A matter of access

Hospitals are pleased with the program because it has cut down on the patient load at their busy EDs.

"We know that the inner-city hospitals are *so* overwhelmed with emergency room utilization. The waits are long and it's not the most conducive way to get medical care," Persichilli says.

Bonaparte has been working with physicians whose patients have a high rate of ED visits.

"Mostly, it is just a matter of access. The doctors have office hours from 10 a.m. to 4 p.m. These members don't have the luxury of going to the doctor during regular hours because they cannot get off work," Bonaparte says.

He's persuaded many of the physicians to increase their office hours to accommodate working parents.

"When people have a true emergency, they should be in the emergency room. When you have members who do not need to be there, it slows the treatment process. It wastes everybody's time and money to have people visit the emergency room for routine care," Bonaparte says.

Pilot projects

The plan has begun a social work pilot project in the emergency department of one of the large hospitals. The hospital gives the Horizon Mercy social worker space to meet with the members in the ED.

"One of the biggest obstacles with Medicaid members is changing their behavior so they do not seek care from the emergency room," Bonaparte says.

As many as 80% of ED visits by Horizon/Mercy's Medicaid population are not for true emergencies, he adds.

"They might have been urgent but they should have occurred in an ambulatory setting," he says.

The social worker meets with Horizon Mercy's Medicaid population who come to the ED and helps them develop a relationship with a primary care physician or specialist provider. She teaches them to use the ED only if there's a life-threatening situation.

"Many times, these members will sit there for hours for something as simple as a child's runny nose. They are afraid they will lose another day of work if they do not stay," he adds. ■

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

- How pharmacy intervention initiatives can increase compliance
- Putting cultural competency into practice
- Ways to measure outcomes in your case management program
- How new technology can improve your efforts

CE questions

6. Presbyterian Health Plan developed its rural case management program because:
A. It needed to give the Albuquerque-based health plan a local face.
B. Rural people are more likely to listen to some one who lives in the community and understands local customs.
C. Many of the rural Medicaid population have no telephones and move frequently so they have to be contacted in creative ways.
D. All of the above

7. With CIGNA Group Insurance's holistic approach to care, if a case manager encounters a disabled patient who isn't recovering according to plan, he or she looks further to see if:
A. The doctor is following standard protocols.
B. The patient may have post-traumatic stress syndrome or another psychiatric condition that interferes with recovery.
C. The patient is lazy and just doesn't want to go back to work.
D. The patient isn't following the treatment plan.

8. According to Carole Stolte-Upman's estimates, approximately what percentage of Chesapeake Disability Management's workers' compensation patients have an underlying comorbidity?
A. About half
B. 20%
C. 75%
D. Nearly all

9. Molly Mettler promotes "information therapy" to help patients make an informed medical decision. This means giving the right person the right information at the right time.
A. True
B. False

10. Horizon/Mercy's social work case management program resulted in what percentage decrease in emergency department utilization in its first six months?
A. 10.2%
B. 35.6%
C. 20.1%
D. 5.4%

Answers: 6. D; 7 B; 8. A; 9. A; 10. C.

CE objectives

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

1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.

2. Explain how those issues affect case managers and clients.

3. Describe practical ways to solve problems that case managers encounter in their daily case management activities. ■

Reports From the Field™

Associations endorse The Quality Initiative

The Kansas, Michigan, and Nebraska hospital associations have joined a growing list of American Hospital Association (AHA)-affiliated associations formally endorsing The Quality Initiative, the voluntary data reporting effort developed by the AHA, the Federation of American Hospitals, and Association of American Medical Colleges.

Their support came as hospital participation in the initiative approached 1,000 in mid-June. Although May 30 marked the deadline for reporting performance data for display on the Centers for Medicare & Medicaid web site, hospitals still can volunteer their participation. For more on The Quality Initiative: A Public Resource on Hospital Performance, visit www.aha.org. ▼

CDC addresses monkeypox cases

The Centers for Disease Control and Prevention (CDC) has issued infection control guidance for managing people in the health care setting and community who may be infected with the monkeypox virus. In a late June news briefing, a CDC official said the agency was investigating 33 cases of possible human infection with the virus in Wisconsin, Indiana, and Illinois, of which four have been confirmed through laboratory testing.

CDC expects more of the cases will be confirmed as testing continues, since most of the people involved have been in contact with ill prairie dogs and have the expected symptoms, which include fever, cough, headache, myalgia, rash, or lymph node enlargement within three weeks after contact with an infected animal. The CDC said standard, contact, and airborne infection control precautions should be applied in all health care settings. Those include hand hygiene and use of gown and gloves for any contact with the patient or care environment, eye protection if splash or spray of body fluids is likely, and N95 respirators or surgical masks for health care personnel. For more information, see the CDC guidance at www.cdc.gov/ncidod/monkeypox/infectioncontrol.htm. ▼

Help from children keeps elderly parents at home

One-third of people age 70 and older with physical limitations received regular help from their children with basic personal care such as eating, bathing, dressing, or maneuvering around their home, although only 7% received help most of the time. About 11% receive both personal care and help with shopping and chores, according to a recent study.

The study findings underscore the importance of family caregiving. Researchers found that disabled Americans age 70 and older who received help from their adult children with basic personal care were 60% less likely to use nursing home care over a two-year period than similar elders who did not receive assistance. The likelihood that people would receive help increased with the number of adult children. Black and Hispanic elders were substantially more likely than whites to receive help from their children.

Initiatives such as respite care, tax breaks for family caregivers, and requirements that employers offer time off or flexible schedules for workers with caregiving responsibilities could reduce costly nursing home admissions by encouraging families to provide care for their elderly parents, wrote **Anthony T. Lo Sasso**, PhD, research associate professor in the Institute for Health Services Research and Policy Studies at Northwestern University in Evanston, IL, and **Richard W. Johnson**, PhD, research associate of the Urban Institute in Washington, DC.[1]

Lo Sasso and Johnson analyzed data on elderly health, assistance from family members, characteristics of adult children, and nursing home admissions from a nationally representative longitudinal survey of more than 7,000 Americans age 70 and older.

Reference

1. Lo Sasso AT, Johnson RW. Does informal care from adult children reduce nursing home admissions for the elderly? *Inquiry* 2002; 39:279-297. ▼

Hospitals to participate in RWJF initiative

The Robert Wood Johnson Foundation has selected 10 hospitals systems to participate in a national program to reduce emergency department (ED) crowding and assess the health care safety net. The health systems will receive up to $125,000 to develop and implement strategies to relieve ED crowding, and will produce a report depicting the state of the safety net in their community.

Four of the health systems also will receive $250,000 to implement specific demonstration projects. Lessons learned from the so-called Urgent Matters project will be disseminated to hospitals and communities nationwide. For more information and a list of participants, visit www.urgentmatters.org/. ▼

HIPAA.ICC.NET created to facilitate transmission

Internet Commerce Corp. (ICC) says it has created a new service to address the need for health care payers and providers to exchange health care transactions that conform with the Health Insurance Portability and Accountability Act (HIPAA) requirements. The new service, known as HIPAA.ICC.NET, incorporates software from eServices Corp. as well as that company's expertise in the new health care transaction requirements.

The company says that HIPAA.ICC.NET provides for seamless transmission of the HIPAA standard transactions between payers and providers.

"In today's health care environment, controlling costs is a major challenge," says ICC marketing vice president **Arnold Capstick**. "This new capability is aimed at providing a highly reliable, secure, accurate service at transaction prices that are more cost-effective than the current norm in the health care industry. HIPAA.ICC.NET allows users to comply with HIPAA regulations with a minimal investment of time and money." ▼

HHS funds centers to serve uninsured

Thirty-one new community health centers are to be funded through $16 million in grants recently awarded by the U.S. Department of Health and Human Services (HHS).

The centers are expected to provide health care services to an estimated 254,000 people, including many who are uninsured, according to an announcement by HHS.

The grants are part of a five-year Health Centers Initiative by the Bush administration to add 1,200 new or expanded health center sites by 2006. The centers will provide preventive and primary care services to patients regardless of their ability to pay. For more on the grants, including a list of recipients, go to www.hhs.gov. ■

Send us Resource Bank items

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

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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. ■