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Covering Case Management Across The Entire Care Continuum

INSIDE

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How much does it cost employers to gain public trust for their CMs?

Liberty Mutual is betting its $30 million will do the job

You know that case managers make the difference in returning employees to work safely and swiftly. You know that a good case manager is a patient's best advocate in a confusing health care delivery system and that case managers are valuable assets to their organizations. But is your employer willing to put up money to get that message out?

Liberty Mutual Group in Boston launched a $30 million radio, print, and television campaign in March to create a warm, caring image with the help of a phrase that mirrors the organization's mission statement: "to help people live safer, more secure lives." Not only do preliminary reports indicate the campaign has been good for business, but case managers featured in the ads have found the campaign has gained them personal recognition both inside and outside of the company.

"Too often, insurance companies are seen as cold. When people think of an insurance company, they see an image of a building without a name or a face," says **Julie K. Johnson**, RN, CCM, assistant vice president of medical and disability management for Liberty Mutual in the Dover, NH, office. "This business is very competitive. If we want to maintain a leading role in workers' comp and other areas in which we provide service, we have to be willing to spend money to maintain our investment."

"Liberty Mutual has always been proactive in helping people live safer more secure lives. People think of insurance companies as big buildings that take in premium checks," agrees **Lynn Newton**, account manager in corporate communications for Liberty Mutual in Boston. "The ad campaign is designed to show that Liberty has experts helping people get back to work quicker — cutting red tape, not creating it. We want to put a human face on the company, and we chose experts whose work lined up with our marketing objectives to create that human face."

Liberty Mutual looked at its 37,000 employees and chose its 400-strong nurse case management division as one of those to highlight in the national campaign. "The selection of nurse case managers, and other experts, was a market-driven decision. We selected departments that would help us create the high-quality, caring image we wanted to present." says Newton. "We went to the managers of each of the product or service divisions selected and asked supervisors to nominate individuals to appear in the ads. We looked for employees who, in talking about their work, could demonstrate that Liberty helps people live safer and more productive lives. It also was a special recognition for the employees chosen."

A healing touch

Both telephonic and on-site case managers are featured in the campaign. "We often think that what we do every day is very routine," notes Johnson. "But when we begin describing the work we do to help employees get back to work, it becomes extraordinary to others. It's not only helped the organization, but it's helped the case management department, as well. When people hear the term 'nurse case manager' now, they associate it with value. This is something we absolutely need — not nice, but necessary."

"I get e-mail from Liberty employees all over the country who have heard the radio ad and want to tell me how great it is," says **Kristy Baum**, RN, BSN, CDMS, an on-site workers' comp medical case manager for Liberty Mutual in Louisville, KY, who was featured in a radio ad. "I think initially employees see the workers' comp case manager in an adversarial role. The ad gave me an opportunity to explain in my own words that even though I work for the insurance company, I have a responsibility to see that treatment is appropriate and things are moving well. Too many people don't understand that this is what we do. The ad gave me a chance to explain my job to others. I was honored."

She says physicians she works with have heard the ads. "I've gone into a doctor's office and had the physician or the staff say, 'I heard you on the radio.' It sparks interest in my role. They say, 'Tell me again what it is you do.' It's been a very positive response. I even had one physician call just to leave me a voice message that he had heard the radio ad. It's given Liberty as a whole a more positive look."

Print ads feature a telephonic case manager with the tag line: "I heal the injured with my index finger." Johnson says she appreciates the opportunity to highlight the entire case management division. "We were able to show both ways we deliver case management services. Our nurses are our best assets. It was wonderful to able to demonstrate to the staff how much they were appreciated by highlighting them in the campaign."

Case managers work hard and are often their own worst critics. "As a manager, it's important for me to remember how important feedback is," notes Johnson. "For the case management staff to see that out of 37,000 employees, two of their own were selected to represent the company was a wonderful affirmation that this division is an important part of our company."

The multimillion-dollar campaign was developed by kirshenbaum bond & partners, a communications company with offices in New York City and San Francisco. Each ad promotes action. Print ads, which appeared in business and financial publications such as *Fortune, Business Week, Smart Money*, and *Working Mother*, include "insurance in action" tips. TV ads appeared during programs such as "Dateline," "60 Minutes," and "20/20."

Naturally, Liberty is paying close attention to the return on its $30 million investment. "We've hired an outside research firm to conduct a study to gauge the effectiveness of the campaign and generate a report every three months," Newton says. "It's a little too soon for a published report at this time, but what we've seen so far is very promising. It looks like this is working."

The ad campaign has attracted local media. "An employee from the Boston-area featured in one of the ads was highlighted in the feature article in the local newspaper," says Johnson. "He works in the research center, and the article talked about all the work he does. That generated some positive public relations for Liberty, as well." ■

COMING IN FUTURE MONTHS

- Taming 'Dr. Difficult': How to gain physician cooperation
- How to hire and retain the best and the brightest
- Multiple sclerosis management update
- Dementia or depression? How to make sure the diagnosis is right
- Gaining support for professional development from the top brass

Ethics requires CMs to look beyond data

Ethical CM requires accountability

Health care is a business. Money is exchanged for a service provided, and that money is necessary to make the system work. But when case managers apply business terms to their patients, they risk losing the ability to provide accountable, ethical, patient-centered care.

"When I call my patient a 'client' or a 'customer,' I don't have the same responsibility or accountability to that individual as I do when I call the individual a patient," says **Carol Taylor**, CSFN, PhD, MSN, RN, assistant professor and ethicist at Georgetown University School of Nursing in Washington, DC. "There is a profoundly ethical dimension to this concept. If all I know about the people entrusted to my care are the numbers associated with their illness, all I can do is address their pathology. I know nothing about how the disease affects this individual or the individual's family. And I can't develop an appropriate, holistic care plan."

Using power compassionately

"Case managers must recognize that their patients are immeasurably better or worse by who they as professionals choose to be on any given day of their practice," she says. "There was a sister in our order dying of ovarian cancer. It was one of the worst, most painful [deaths] I've ever seen. One day, she told me, 'When I first got sick, it didn't matter how people treated me because I knew who I was. As I've gotten weaker, I've become whoever people make me. If they come in and move me like I'm meat, then I am meat.'"

That's the power case managers have over the patients they work with, notes Taylor. "That's the power we hold. How will we use it? How do we look at systems of care in terms of making people feel like they are human beings?"

For Taylor, it's imperative that experienced case managers work with younger, less experienced case managers to establish guidelines for ethical, accountable practice. "There is a shortage of qualified, experienced case managers in this country. We are taking nurses and social workers with less and less experience and putting them into case manager roles where they are working solo," she notes. "They don't have the experience to draw on. They only know what the book says, and we are in danger of delivering cookbook care. The repercussions of their inexperience will come back to you. What if you are the next case manager an individual meets? The public is deciding what we are about and what they think about us based on the actions of other case managers they encounter."

For example, she says, what if an elderly woman tells the case manager she doesn't believe her husband's pain medicine is working. The case manager says "I'll look into it" but never does. "That couple doesn't just distrust that case manager. If I'm the next health care professional they met, they won't trust me, either. It will make my job harder." **(For information on the qualities of an ethical case manager, see p. 141. For suggested assessment activities, also see p. 141.)**

Taylor says there are six elements case managers can be taught to help them provide more accountable and ethical care. They are:

1. **Affective element.** "This is my capacity to be moved by the patient entrusted to my care," explains Taylor. "The professional caregiver has an obligation to move beyond any personal regard they have for an individual and say, 'Here is a human being in need,' even if this is the patient from hell and you don't like this person, you have an obligation to care," she says. "That is how being a professional caregiver differs from being some one else. We have an obligation to be moved by groups in society that don't have anybody else to be moved by their plight."

2. **Cognitive element.** "This means that you are not just moved by your patient's plight, but you know how to improve their current state," she says. "If I'm a daughter, and my mother is in a postoperative stage and I don't know how to relieve her pain, that doesn't make me a bad daughter. However, if I'm the mother's case manager or her nurse or her surgeon, and I don't know how to relieve her pain, I am a deficient caregiver. An accountable case manager must be both caring and competent."

3. **Volitional element.** "I can be moved by the people in my care. I can know how to help the people in my care. However, if I don't take action to improve their state, I'm worthless," she says.

4. **Imaginative element.** "This goes back to building relationships. This is my ability to find

Fun with ethics

Role-playing can clarify issues

Role-playing is a useful tool to help case managers understand how their actions affect the patients in their caseload, says **Carol Taylor**, CSFN, PhD, MSN, RN, assistant professor and ethicist at Georgetown University School of Nursing in Washington, DC. "Case managers literally hold human well-being in [our] hands. For our patients, their illness or injury is a once-in-a-lifetime experience. How we respond, how we treat our patients, affects the public trust in the entire health care system. If I treat my patient poorly, my patient will not react well to the next case manager, or nurse, or physician, or therapist they encounter. If we don't convince the public that we are worthy of their trust, then it's buyer beware," she cautions.

(For more suggestions for teaching accountability and ethical case management, see p. 139.)

Here are three role-playing scenarios Taylor uses in an ethics and accountability exercise. First, role-play the scenarios below with your colleagues and then discuss how the case manager responds, or fails to respond, is likely to influence the patient. It's also helpful to discuss both how you think case managers in your practice would respond to this type of situation and how you think they should respond, notes Taylor. "If the 'would' and the 'should' differ, discuss why."

Scenario one: You are making the first home visit to a 60-year-old man with early Alzheimer's disease who has just returned from a rehabilitation stay following a surgical hip repair. He is fiercely independent and seems to have mastered good self-help behaviors. His wife, on the other hand, seems totally at a loss and confides to you that she is terrified to have her husband home and has no idea how to cope. She asks you if it is at all possible to get him admitted to a nursing home. You suspect that her request is premature and feel certain her husband would not want to leave home.

Scenario two: Another nurse tells you that she's utterly frustrated because the doctor refuses to talk with a patient about advanced directives because "it might depress her." You share this nurse's belief that the patient wants to participate in decision making and that it is very possible that she will lose the ability to do this soon.

Scenario three: You are making a home visit to a 62-year-old man with end-stage AIDS. He tells you that he is tired of fighting, has no money, and no longer wants to be a bother to his friends. He asks you what he can do to end his life. ■

out the unique needs of the individual in my care," she explains. "Do I really know what this individual needs and wants?"

For some elderly patients, pneumonia may be a blessing, she notes. "You may have a patient who says, 'Hallelujah, I've been waiting to die.' There are others who say, 'Oh, no. I'm not ready yet.' Which is your patient? Do you know? Should you make the patient comfortable at home, or do you rush to the hospital for IV antibiotics? How can you develop an appropriate plan, if you don't know your patient's wishes?"

5. **Motivational element.** "We have many motivations for what we do. For health care professionals, the primary motivation has to be a commitment to secure the interests of the people we serve," says Taylor. "We are seeing legislative attempts to fix the evils of managed care because the public no longer trusts us or sees us as having the power to fix those evils for them."

6. **Expressive element.** "I must express my caring in such a way that it is perceived as caring by my patient and my patient's family," she says. "You can express yourself in verbal and nonverbal ways. Every time you look at your patient, you can leave the impression that the patient is an object, a job to be done, or a person of worth. Every time you interact with your patient, you will give one of three messages: 'Drop dead.' 'You are nothing.' 'You are worthy, and I care about you.'"

Case managers face ethical dilemmas daily, notes Taylor. "The question is, what do I allow to happen? Is this illegal as well as immoral? We can't fight every battle, but do we understand which battles must be fought? The key is that internal voice," she explains. "If a situation makes you uncomfortable, don't turn off your discomfort. Pay attention to that discomfort. The day you turn off that discomfort, [resign] and sell shoes, but don't do health care." ■

How to measure ethics among potential CMs

Evaluating ethics before hiring makes good sense

It's possible to measure a case manager's ethics and use ethical competency as one of your employment criteria for hiring, advancement, and firing, says **Carol Taylor**, CSFN, PhD, MSN, RN, assistant professor and ethicist at Georgetown University School of Nursing in Washington, DC.

"You should write scenarios that are common to your own practice. Select issues that recur often and present them to case managers, or potential case managers," she suggests. "What you are looking for is evidence that they've had experience working with the types of ethical problems common to your practice. As you listen to the person's response, ask yourself, "Does this person have the qualities we're looking for?'"

Three sample scenarios

Taylor wrote the following scenarios for use in her own teaching hospital setting.

Scenario one: The wife of a patient with end-stage cancer seeks you out and tells you she is afraid that her husband is "losing hope" and "giving up." She tells you she has just learned that one of the patients on the unit was evaluated for inclusion in a clinical trial that offers some promise of arresting the disease if the patient receives the experimental drug. She wants you to get her husband in this trial and to do whatever you can to ensure that he receives the experimental drug. You aren't familiar with the criteria for inclusion in this trial and think it probably would be futile for her husband, given his condition. You have to be at an administrative meeting in 20 minutes. What do you say to her?

Taylor suggests evaluating a potential employee's response to that scenario for the following issues:

- commitment to patient well-being;
- sense of responsibility and accountability;
- advocacy competencies.

Scenario two: A woman who has just had a large nonmalignant abdominal mass surgically removed is seen by the case manager from her health maintenance organization (HMO) on her second postoperative day and told she needs to be discharged. She tearfully tells you she is not ready to go home, and you suspect her elderly husband will be a rather limited source of assistance. When you try to explain her situation to the HMO, the representative you speak with is adamant that the company will not reimburse for any additional days. The size of the patient's mass, the length of time she was in the operating room, other factors in her history, and her limited at-home resources place her at higher risk for complications than other patients undergoing

What it means to be ethical

Seven qualities of an ethical case manager

There's much more to being a case manager than simply completing an appropriate education and several years of clinical experience. A true case manager is a patient advocate who helps patients navigate the stormy waters of the health care system when they are at their most vulnerable.

Effective case management takes ethical competence, and to develop that competence case managers must practice in a manner that is consistent with their morals and their profession's code of ethics, says **Carol Taylor**, CSFN, PhD, MSN, RN, assistant professor and ethicist at Georgetown University School of Nursing in Washington, DC.

Taylor says ethical case managers possess the following seven qualities:

- clinical competence;
- ability to act in ways that advance the best interests of the patients entrusted to their care;
- ability to hold themselves and their colleagues accountable for their practice;
- ability to work collaboratively to advocate for patients;
- ability to mediate ethical conflict among the patient, significant others, the health care team, payers, and other interested parties;
- ability to recognize the ethical dimensions of practice and identify and respond to ethical problems;
- ability to critique new health care technologies and changes in the way we define, administer, deliver, and finance health care in light of their potential to influence human well-being. ■

similar surgery. What actions, if any, would you take?

Taylor suggests evaluating the candidate's response for the following issues:

- commitment to patient well-being;
- sense of responsibility and accountability;
- advocacy competencies;
- ability to critique the system's potential to influence human well-being.

Scenario three: An 84-year-old Native American resident on your rehabilitation unit tells you to make sure that "Ellen never takes care of me again." When you question him, he tells you how "mean" she is and that she never treats him nicely like the other nurses do. You respect Ellen's clinical competence and know that this patient has a reputation for being a problem. What would you do?

In addition to evaluating the response for commitment to patient well-being and a sense of responsibility and accountability, Taylor suggests you evaluate the candidate's ability to be an effective advocate and mediate between Ellen and the patient. ■

Workers' comp/disability management

Migraine program cuts lost work days

Physician says desktop application next step

Headache contributes to absenteeism and productivity loss in the workplace, according to national studies. A pilot computer-based workplace migraine program not only reduced lost workdays but showed improvement in overall function and health in just three months.

J.P. Morgan & Co., with offices in New York and Delaware, came forward to pilot the Migraine Matrix program developed by the care management division of Glaxo Wellcome in Research Triangle Park, NC, because headache and allergy are second only to stress in attracting employee attendance at the corporate health seminars. "Headache results in people not working as efficiently. They come in but they don't work well," says **William J. Schneider**, MD, MPH, director of health services at J.P. Morgan & Co. in New York.

"We really didn't know how many employees would come forward for the program. We anticipated about 16% of our population would turn out to be chronic headache sufferers based on population studies. We found we had nearly twice that." **(For suggested reading on the impact of headaches on the workplace, see end of article.)**

J.P. Morgan used several methods to recruit employees to participate in the program, Schneider says, including the following:

- corporate electronic mail describing the program;
- notices in company newsletters;
- ads on the corporate televised announcement system;
- posters in medical departments and lobbies;
- tabletop ads in the cafeteria.

In addition, the company provided incentives such as a corporate-monogrammed leather cardholder for completing the baseline screening session and entrance in a drawing to win free airline miles for participants who completed the follow-up assessment, says Schneider.

There were 475 total program participants, with 428 completing either a baseline or follow-up session for a completion rate of 92%. Of the 185 participants who completed both the baseline screening and the three-month follow-up assessment, 177 were evaluable for study outcomes. The other eight met criteria for urgent assessment and were referred to a physician.

Inside the matrix

Kiosks were set up in the workplace for participant use. The kiosks contained a multimedia computer equipped with a touch screen monitor and memory sufficient to hold visual presentations. They also contained printed educational materials. To avoid waiting lines, employees interested in participating were required to schedule an appointment through the medical department to use the kiosks, notes Schneider. "This was one drawback of the program. Our population, like all work populations, is very busy. It's not easy to commit them to pull away from their desks for 20 to 30 minutes in the middle of the day to go to a kiosk and answer questions. The kiosks were set up at fixed locations. It took time for employees to access [them]."

Participants answered questions about the clinical, social, and economic impact of their

headaches at both baseline and follow-up. Two educational reports were generated for participants who completed the headache screen, with one sent to the employee and the other to the employee's health care provider.

The employee report includes the following information based on each individual's responses to the questions:

- description of migraine symptoms;
- potential causes of the migraines;
- individuals' opinions of the causes;
- suggested actions to decrease frequency and severity of migraines;
- encouragement for patients to take the report to their next physician's office visit.

The health care provider report includes:

- identification of the type of headache or migraine the patient suffers from;
- description of the frequency and severity of the headaches reported by patients;
- headache-related disability factors, such as lost work days;
- headache risk factors reported by the patient;
- other headache-related information, such as health care utilization related to headache;
- patient satisfaction with current headache treatment.

The Migraine Matrix assessment tool assigns a headache magnitude score for each participants based on responses to questions about symptoms, effect of headache on productivity, health care utilization, comorbidities, and lifestyle. To protect the confidentiality of employees, data analysis was performed by an independent firm.

Participants were encouraged to complete the three-month follow-up assessment by electronic mail and telephone. During the follow-up assessment, participants responded to different questions designed to indicate any changes in their headaches and the impact of their headaches on their function at both work and home.

Study outcomes include the following:

- 29% of participants previously were under a doctor's care for headache, and 35% were actively receiving a doctor's care for headache at the time of participation in the program.
- 19% of participants visited a physician for headache following the baseline screening.
- The mean number of days with headache in the past four weeks decreased from 5.5 at baseline assessment to 4 at follow-up. The results were similar for participants treated by physicians and those not treated by physicians.
- 56% of participants reported improvement in their headache symptoms at follow-up.
- For those participants who reported urgent care or emergency room treatment for headache at baseline, the mean number of visits decreased from 1.74 for six months before baseline to 0.42 visits at follow-up.
- 32% reported lost workdays due to headache at baseline. The mean number of workdays lost was 0.35 a month at baseline and 0.25 a month at follow-up, for an improvement of 29%.

The big chill

Schneider says that although the program had a positive effect, the pilot did indicate there was room for improvement. "The program works, but it's disruptive on people's routines to require them to leave their workstations to access a fixed location," he notes. "Some employees may even have chosen not to access the kiosks because they didn't want to be seen by co-workers. There's that feeling that people are watching."

Although staff were given the opportunity to revisit the kiosks for more information, none did, except to complete their follow-up assessment, he says. "Glaxo is working to refine the database so it is more compact and organizations can introduce the Migraine Matrix program through their company's intranet. This way, employees can receive much of the same information without even leaving their desks. Even though screens were placed around the kiosks for privacy, sitting at your own desk provides much greater privacy.

"We found that use of a fixed site just doesn't work in this electronic age," says Schneider. "I'm sure that we would have had even greater participation if we had been able to provide the same information available at the kiosks at our employees' work stations."

Suggested reading

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Creating single contact improves Alzheimer's care

MCO finds too many cooks spoil the broth

Alzheimer's patients have wide-ranging medical, social, and psychological needs. But when too many providers are involved, with no single point of contact and coordination, the result is less than optimum care. Kaiser Permanente recently piloted an Alzheimer's care project at six sites nationwide that shows great promise for eliminating barriers that often prevent Alzheimer's patients from receiving appropriate, holistic care that addresses those diverse needs.

"What typically happens is that people with dementia and their family members think that the only source of information and care is the physician. They hesitate to make an appointment just to receive information about their condition, and we've found that information is the greatest need for both Alzheimer's patients and their families," notes **Ingrid Venohr**, RN, PhD, director of senior programs for Kaiser Permanente Colorado Region in Denver and a senior researcher for the pilot program.

"Not all caregivers are receptive or quick to grab for help. They often struggle alone for months. In fact, one of our biggest problems with this grant was to simply identify members appropriate for participation and getting members to access the services available," says Venohr. Kaiser Permanente set out to design a new system of care for Alzheimer's patients with a primary goal providing the information, resources, and support services necessary to prevent complications that lead to costs such as premature nursing home admissions. "An essential first step was to educate our physicians and their staffs about Alzheimer's. We created a manual to educate physicians and their staffs about the components of appropriate Alzheimer's care. The manual lays out what is core content that Kaiser sites must cover with providers, and what is optional material," Venohr notes. (The manual includes the new Alzheimer's guideline developed by the California Workgroup on Alzheimer's Disease Management. **For more information on the guidelines and suggestions for Alzheimer's training programs, see *Case Management Advisor*, August 1999, pp. 124-126.**)

The pilot programs had local variations, but each of the six sites developed models of care that included these core components:

- member/caregiver education programs;
- provider education programs;
- caregiver support programs;
- formal links with community resources;
- single point of information contact for caregivers;
- mechanism for using volunteers and/or community health workers;
- mechanisms for identifying patients with Alzheimer's.

"The most important component of the program is that single point of contact. Too many times, the diverse needs of Alzheimer's patients go unmet because family members simply don't know who to contact," Venohr says. "The six sites each had a telephone number staffed by social workers or nurses trained to refer family members to case management and other resources. The number can also be used by community agencies to ask us to look at a member more carefully or address a specific problem that has been identified by the agency."

"Too many times, the diverse needs of Alzheimer's patients go unmet simply because family members simply don't know who to contact."

To encourage caregivers to use the contact line, Kaiser provided physicians with preprinted prescription pads with the contact number printed on it. "It also included referrals for caregiver education and support programs," she says. "The idea was to make education, support, and community referrals appear like a physician's order to increase the likelihood that caregivers would call us and use the available services."

Unfortunately, the system often breaks down over time. "It seems like for every project there's a preprinted pad. Physicians stop using them after awhile. You have to be creative and keep coming up with new ways to attract attention to your programs," says Venohr. "The project director at one site went from exam room to exam room and attached sticky notes with the Alzheimer's project contact number on it to the computer monitors provided in each exam room for electronic medical records."

Venohr says one of the strengths of the program is that it allows each site to implement the core components in the most effective way, based on local variances. "For example, the program requires each site to provide caregiver support but allows each site to provide that support in its own way. In Colorado, we refer to existing caregiver support programs. In San Diego, they provide their own caregiver support programs," she says, adding that the Alzheimer's Association is an excellent source of caregiver support programs as well as education.

"Learning from other caregivers is very powerful. Support groups work best when they include a mix of caregivers dealing with Alzheimer's patients at different stages. In that way, caregivers learn what to expect when their loved ones reach the next stage. It helps them anticipate what's coming and plan ahead," she says. "It also helps them recognize signs or clues that a behavior, such as wandering at night, is about to begin. Often those are the behaviors that lead to an admission. If the caregiver had only recognized the early signs, we could have prevented a crisis."

Senior volunteers offer support

One of the six sites included a senior volunteer program in its Alzheimer's care program. "The site uses specially trained senior volunteers to call caregivers and ask them about their own health and whether they have any new needs," Venohr says. "The senior volunteers offer reassurance and support through weekly telephone calls and help the health plan detect problems earlier.

"The bottom line is that physicians have limited time to spend with patients, and families aren't always comfortable turning to the physician for education and support services. We're used to the physician being in a hurry. We don't look for physicians to provide information or education," she says.

"We have to improve our system of care to link Alzheimer's patients and their families earlier and more effectively with the education and support services that help them live longer, more comfortable lives in the community," she adds. "That means that insurance plans and health systems must be more proactive in linking patients with community-based services, and the key to making it work is providing a single point of contact — a number families can call to arrange all of the services and receive all of the education they need."

Kaiser now plans to interview caregivers to get a better feel for what their real needs include, notes Venohr. "Many of the programs health plans and health systems develop are simply not accessible to the majority of members. We need to have a better understanding of what caregivers need and how we can meet those needs. You must check in with your customers if you want to develop effective interventions." ■

Disease management

Diabetes program enters second stage

MCO finds it's best to walk before you run

The benefits of disease management programs for utilization and medical cost reductions now are widely accepted. However, once those initial objectives are met, it's time to switch your focus from appropriate allocation of services to improving the overall health and quality of life for plan members.

"Discovering and applying effective ways to care for our members with chronic illness results in productive individuals who enjoy good quality of life and, ultimately, in lower health care costs. Since those goals are aligned with those of corporate and government purchasers, they are also good business," says **Robert L. Crocker**, MD, national medical director of care management services for UNICARE in Thousand Oaks, CA.

As the managed care industry matures, health plans must move beyond utilization trends to a best outcomes focus, notes Crocker. "As organizations, we must shift our focus to best outcomes. That's the direction UNICARE is heading, and I firmly believe it's where the entire industry must move. You reach a point where you've done all you can with controlling overuse and misuse of health care services, and there is a point of diminishing returns. Disease management is a natural outgrowth of the maturation of the managed care industry, and the shift from measurement and improvement of utilization trends to measurement and improvement of quality of life and clinical indicators is the natural maturation of a disease management program."

To meet the challenge of controlling one chronic disease, diabetes, UNICARE conducted a pilot program involving 35 patients from spring 1997 to spring 1998. The goal was to test whether combining early identification, direct intervention, personal contact, member education, and a team approach among providers — all based on best treatment practice guidelines — could result in improved health.

Encouraging the use of appropriate services led to a dramatic decrease in the need for acute inpatient care. Participants saw their physicians and used other outpatient services 250% more often than they did before enrolling in the program. Consequently, hospital admissions declined by nearly 40%. There was nearly a 50% reduction in overall hospital bed days and a 17% decrease in hospital length of stay per participant.

Medical professionals involved in the program were not entirely surprised by these results, says Crocker. "The stage had been set for favorable outcomes. Patients were educated and motivated, they were cared for according to the best guidelines we now have for treating diabetes, and they benefited from continual personal contact with medical professionals."

Benefits of education are far-ranging

The results of the pilot diabetes management program validate UNICARE's "member first" philosophy, he says. "The benefits of taking an active role in one's health care are far-ranging. As caregivers, we have seen that members with chronic conditions who are empowered through education and commitment to a treatment plan are less likely to feel they are 'victims' of their disease. And they are less likely to experience the feelings of helplessness that follow a serious diagnosis."

While the success of the disease management program is very good news to individuals living with chronic diseases, it also is significant to UNICARE's employer customers, Crocker says. "A chronic condition such as diabetes or asthma can take its toll in lost work time and underperformance. A successful disease management program provides the needed support for an individual with a chronic illness to continue contributing on the job and in the rest of his or her life," he notes, adding that UNICARE's diabetes management program now includes more than 400 patients.

The program began with a crucial step: early identification. UNICARE case managers, using a selective screening process, identified members whose diabetes was not well controlled, placing them at risk of serious complications. These at-risk patients were identified through claims and pharmacy benefit data or through calls requesting hospitalization or home care. A sure sign that these members needed help managing their disease was that they had high rates of hospital admission.

Outreach program identifies candidates

Once candidates for the program were identified, a systematic outreach process was set in motion. A letter was sent to each patient stating that, based on the patient's specific diagnoses, he or she was eligible to participate in the diabetes management program. The letter outlined how patients could benefit from services available through the program, whose goal was to improve their health and keep them feeling their best.

UNICARE case managers subsequently contacted patients by phone to perform a detailed evaluation. "We learned when they were diagnosed with diabetes what other diagnoses they had and the extent of their knowledge about their diabetes. The assessment also pinpointed their level of diabetes control, understanding of their current treatment plan and individual circumstances that could be a barrier to better health, such as home or work situations," says Crocker. With the participant's permission, case managers contacted the treating physician to confirm the treatment plan and obtain information about the patient's overall control of their diabetes.

Each patient then received educational materials that served as key learning tools and a means for UNICARE nurses to determine the patients' level of understanding of their disease. Each patient received a booklet on Type 1 or Type 2 diabetes, as appropriate. In addition, patients received a booklet on nutrition, if their assessment indicated they needed help in learning to eat correctly.

The booklets, produced by a commercial publisher of patient education materials, were written in simple terms and included illustrations, Crocker says. The materials explained the disease and its treatment and included tips on ways to keep it under control, such as exercise and diet.

Nurses followed up with members to determine whether patients had read and understood these materials. Nurses assisted patients with literacy problems to comprehend the concepts, and the

nurses referred patients to outpatient diabetes education centers for further help when necessary.

UNICARE case managers then worked directly with members and their caregivers — physicians, nurses, diabetes educators, and other professionals — to ensure that best practice guidelines were followed. The caregiver team stressed the importance of a key method of diabetes control: the quarterly $HgbA_{1C}$ blood test recommended by the American Diabetes Association in Alexandria, VA. The test demonstrates the patient's average blood sugar control for the previous three months. Because the test is unfamiliar not only to many patients, but also to some primary care providers, UNICARE nurse educators contacted physicians to remind them of the need to draw blood from these patients quarterly to perform the test.

UNICARE nurse case managers also facilitated access to education and support. They suggested resources convenient to patients such as outpatient diabetes education centers, diabetes clinics, or support groups. If some patients preferred not to visit a diabetes education center, then our nurses provided one-on-one education and information.

Nurses put patients in control

While physicians directed care and examined each member regularly, nurses encouraged and motivated patients to take control of their own health and manage their condition. For example, patients were instructed on how to examine their feet daily for areas of redness, discoloration, and swelling; how to trim their toenails to avoid cutting too close and causing ingrown toenails and infections; and how to choose proper footwear. Since many diabetics lose parts of their feet and limbs because they don't examine their feet every day, these careful, detailed instructions helped prevent serious complications.

Continual support and ongoing follow-up, based on each patient's symptoms and individual need for education, resulted in patients who understood and actively pursued a proven regimen that enhanced their health and well-being. An important aspect of the program is that it supported the work of treating physicians, who found themselves caring for better-educated, more compliant and motivated patients, says Crocker.

"The interesting thing that case managers found as they acted as intermediaries between the patients and their physicians is that often patients are told 'A' but hear 'B,'" he says. "Case managers have a wonderful opportunity to help participants cross that bridge. Our case managers would call providers and say, 'Your patient has enrolled in our program and tells me this is what you've instructed them.' Many times, physicians would immediately say, 'That's not what I meant at all.' The case managers would then contact the patient and clarify the physician's orders."

As UNICARE's diabetes management program moves forward — enrollment has increased from 35 to 400 — the next phase is to measure utilization data as well as quality of life and clinical indicators. Measurements being gathered from participants include the following:

- $HgbA_{1C}$ levels;
- compliance with treatment plans;
- self-reported days lost from work or school;
- other quality-of-life indicators such as self-reported health and well-being.

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"Some conditions, such as asthma, have immediate short-term returns that can be easily measured. For other conditions, such as diabetes, it's more a matter of preventing long-term complications. In the short-term, we often see a temporary increase in outpatient services as we encourage regular testing and examinations. The real returns come later. That's the challenge, and that's the balance," says Crocker. "You have to walk before you run, but now we must move beyond utilization measurement and look in other areas for appropriate outcomes that help us monitor our success. It's a challenge, but one that those of us developing disease management programs must be willing to accept." ■

Managed care

Empowered patients are happy patients

A new study released by Press, Ganey in South Bend, IN, confirms an emerging trend in health care — today's patients want to know their rights and what to expect. The consulting firm compiled data from a quarter of a million patients in 476 hospitals with an average of 525 patients per hospital completing the surveys.

The surveys focused on whether hospitals informed patients about their rights as patients. The study found that patients are more satisfied when health care organizations help them understand their rights. Findings include:

• The mean score for overall satisfaction with the health care facility was 84.9% for patients who received information about their rights.

• The mean score for overall satisfaction for patients who did not receive information about their rights was 81.2%.

"Patients are naturally more satisfied when they are empowered through knowledge. They want to be informed, they want to have choices, and they want to be protected," says **Rodney F. Ganey**, chief executive officer of Press, Ganey. "Successful health care organizations will be those that respect the role the patient plays in decision making. They must create an environment where patients are both protected and empowered." ■

CE objectives

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

1. List organizational benefits of promoting your case management staff.
2. List the qualities of an ethical case manager.
3. Develop practice appropriate ethics scenarios for use in hiring and evaluation process.
4. Describe the benefits of creating a single point of contact for Alzheimer's caregivers. ■