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Patient-centered focus improves case management outcomes

Members set personal goals rather than clinical milestones

When the case managers at HealthPartners work with patients who are at risk for clinical complications, they focus on helping their clients meet personal goals, not those of the health care organization.

"It's important to be patient centered and know what the patient's goal is. Then everything else lines up with that," says **Karen Kraemer,** RN, CMC, senior director of HealthPartners case management program. If the case managers know a patient's personal goals, they can help them set clinical goals and understand what they need to do to attain the goal."

HealthPartners is an integrated nonprofit health care organization based in Bloomington, MN, that provides health services, insurance, and HMO coverage to more than 670,000 members.

Members are treated by the HealthPartners medical group and clinic or by contracted medical groups or health care systems.

When asked about their health care goals, patients don't want to say they want to get their hemoglobin A_{1C} to a certain level, Kraemer reports.

Instead, they tell their case manager that they want to be able to walk their daughter down the aisle in a few months or travel to see the birth of their grandchild, Kraemer says.

One young girl with a debilitating disease wanted to be able to attend her senior prom and walk down the aisle with her class at her high school graduation.

Finding the patient's main goal is a major motivating factor, says **Diane Reuss**, RN, CMC, outpatient case manager.

"The goal may not be health-oriented, but we help connect it so that they see that if they make a lifestyle change, they may be able to meet that goal," she adds.

For example, an older woman told Reuss that she wanted to be able to clean her house, go grocery shopping, and take care of other activities of daily living independently. She needed knee replacement surgery to

be able to do so, but her weight, diabetes, and hypertension made the surgery risky.

Reuss referred the client to HealthPartners' Center for Health Promotion's diabetic education program and called her frequently to reinforce the dietary and lifestyle changes.

With Reuss' encouragement, the woman started exercising, improved her diet, and got her blood sugar, blood pressure, and weight down so she could have the surgery.

Since HealthPartners began its outpatient case management program, the per-member per-month cost has dropped 24.7% and the hospitalization rate for those patients has dropped 48%.

The proportion of members on the registry who have active care plans is at 96%, compared with around 85% in 2002. An active care plan means the member has agreed to take at least one meaningful action to improve his or her health.

Studies by Status One, a medical management company with which HealthPartners contracts to identify patients for its case management programs, show that health plans begin to see a financial return when 70% of their members have active care plans, Kraemer says.

The patients' acuity level has improved by 7% since the program started.

The members' self-reported functional status has increased 13%, and the number of people who report that their functioning is "poor" is steadily decreasing.

"All of the indicators tell us we are having an impact, not only financially but from a patient assessment of functional status and their risk for acute care services," Kraemer says.

HealthPartners' outpatient case management program is very different from traditional case management and disease management.

"These people aren't getting triggered because of a financial threshold or a particular diagnosis. They are picked for the program because of the potential that they will need acute care," Kraemer adds.

Through a partnership with StatusOne, HealthPartners identifies people who may be at risk for health care problems through a predictive modeling system.

The software takes claims, pharmacy, and membership data and uses a proprietary algorithm to develop a clinical profile on highest-risk patients. The patients who are most likely to develop clinical complications with high costs within a year are assigned to nurse case managers.

"The algorithm is not based on disease or financial costs. These are people who are at risk for major health problems, not just those who cost a lot of money," Kraemer says.

Referrals also come from physicians, from inpatient case managers, from HealthPartners' Center for Health Promotions health assessment and education program, and from community organizations whose staff are familiar with the services that HealthPartners provides for members.

Case managers call each member in the program, conduct an assessment, find out what their concerns are, and work with them on lifestyle changes, goals, and priorities, Reuss says.

"We look at the whole person, not just the diagnosis and one specific disease. We look at what could be the causative factor for their problems. It

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Editorial Questions

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

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Editor: **Mary Booth Thomas**, (770) 934-1440, (marybootht@aol.com).
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@thomson.com).
Managing Editor: **Russ Underwood**, (404) 262-5521, (russ.underwood@thomson.com).
Production Editor: **Nancy McCreary**.

could be diet, smoking, lack of exercise, or emotional factors such as stress or depression," she says.

The patients in HealthPartners' case management program often have five or six comorbid issues along with significant psychosocial issues. Almost all of them are depressed. Either they haven't been diagnosed or they aren't following through and getting help. The case managers are trained by HealthPartners' behavioral health team to screen for depression.

"We work with their physicians to make sure that the medical and emotional goals mesh and collaborate with their physicians to make sure we're both coming from the same direction," Reuss adds.

Based on the case manager's assessment and clinical judgment, patients are assigned an acuity level. An acuity level of 1 means the patient is likely to be hospitalized within one to three months. Members who achieve acuity level 5 are ready to be discharged from the program. The acuity level determines the minimum contacts the case managers will make with the patients.

The case managers help the members overcome any obstacles to getting care and reaching their goals.

They may not be able to get to their physician's appointment because they have transportation problems, or they may not be able to cook healthy meals for themselves.

"Any of these problems could result in the patient landing in the hospital," Kraemer adds.

Once these barriers are removed and the patients start to feel better, they are ready to tackle something else, Kraemer adds.

For instance one girl who was legally blind lost her ride to the clinic. The case managers gave her information on transportation options that got her back on track with her physician visits.

The case managers focus on helping the patients become self-reliant. For instance, the case managers don't make the transportation arrangements. Instead, they give the members the information they need to arrange their own transportation.

"We don't want them to become dependent on the health care system. We want to promote independence and self-reliance. It not only helps the system but it helps them feel good about themselves," she adds.

The case managers help patients connect with community agencies and other services they may need.

For instance, one of Reuss' clients was very sick but wanted to travel by car to Wisconsin to see his brother, who was dying. Reuss helped him find places along the way where he could replenish his oxygen supply. She found places along the route where he could get his blood drawn and made sure he had enough medication for the trip.

"In this case, we had to work with long-distance carriers to make sure the patient would be safe during his journey," she says.

HealthPartners has about 3,000 patients on the case management registry and 30 case managers who manage an average of 80-100 patients each.

The case managers are assigned according to the care systems, which include the HealthPartners medical group and clinic as well as a number of other medical groups and independent physicians that have contracts with Health Partners.

"Nurses are assigned according to care system so they can build relationships with those physicians and understand how that particular care system works," Kraemer explains.

Depending on the patient load, case managers may cover several medical groups, or several may be assigned to one large medical group. The patient identifier algorithm is based on the pattern of care, treatment, and place of service.

"We look at case loads and acuity levels; and if we need to juggle the patient load, we do so, but for the most part, we are able to divvy up patient care based on which clinic or medical group cares for the patient," Kraemer says. ■

Readiness to change key to meeting CM goals

Members should be in the action phase

Nurses in HealthPartners' outpatient case management program go through extensive training to help them assess a patient's readiness to change.

"It is important for the case managers to find out the patients' stage of readiness in order to create interactions, conversations, and means of motivating them to change," says **Karen Kraemer**, RN, CMC, senior director of Bloomington, MN-based HealthPartners' case management program.

The case managers have to be astute in assessing whether a patient is ready to make a major lifestyle change or is just contemplating it.

"If they are only contemplating change, it will make it worse if you treat them as if they are further along," Kraemer adds.

The case managers use their motivational interviewing skills and ask open-ended questions to help determine a patient's willingness to change, says **Diane Reuss**, RN, CMC, outpatient case manager.

"Sometimes I start hearing little hints, like 'my family is making me do this.' That's when I know that they aren't in the action phase yet, because they're being pushed to change," she says.

The case managers don't press the members to make changes, but they do keep reminding them of the changes they need to make.

For instance, if a member is a smoker and has trouble breathing, the case manager will say something like, "I know you're not ready to quit smoking, but you need to remember that it's contributing to your health problems."

"We use our nursing expertise to help them choose their priorities and what actions will affect them most," Reuss adds.

For instance, if a diabetic with fluctuating blood sugar levels says he or she wants to lose weight, stop smoking, and exercise, the case managers suggest that they focus first on the diet because that will help them more in the short term.

Health actions, or steps the patient takes to improve their health and care, are the centerpiece of HealthPartners' case management initiatives.

The patients agree to take action on something that is meaningful to them that actually will make a positive impact on their health. The members make an agreement to achieve their goal by a certain time.

"The case manager coaches the patient along in making their choices regarding the action they, themselves, will take. This is patient-driven, not case manager-driven," Kraemer says.

Health actions focus in the following areas:

1. coordination of medical care;
2. self-reliance;
3. daily activity and fitness;
4. interdependence with family and friends;
5. mental challenges;
6. community involvement and purpose.

The readiness to change assessment is based on the findings of **James Prochaska**, PhD, professor of clinical and health psychology at the University of Rhode Island.

Following the model of a book club, the case managers at HealthPartners have read and discussed Prochaska's book, *Changing for Good*.[1]

They read a chapter each month, then get together, and talk about how to apply it. Then they use the skills they learned in the book with their patients.

Reference

1. Prochaska J, Norcross J, Diclemete C. *Changing for Good.* New York City: William Morrow & Co.; 1994. ■

Face-to-face CM is key to HIV-AIDS program

CM helps with medical, social issues

When a member of Worcester, MA-based Fallon Community Health Plan is newly diagnosed with HIV-AIDS, the first person he or she is likely to see is **Rita Wesolowski**, RN, BSN, ACRN, the HIV-AIDS on-site care manager.

Wesolowski works at the Fallon Clinic's division of infectious disease, where the majority of the health plan's HIV-AIDS patients are treated.

Most of Fallon Community Health Plan's disease management care managers work with their clients over the telephone, according to **Wally Mlynaryk**, MHA, director of disease management for the health plan.

"When we developed the protocol for HIV-AIDS, we looked at what was working in other programs. We decided that it would be more effective to work with the patients directly in the clinical setting. Rita has a clinical focus and performs nursing duties, but she goes beyond that in terms of helping patients," Mlynaryk adds.

Fallon Community Health Plan covers about 185,000 members, about 70% of whom receive services from Fallon Clinic physicians. About 85% of the patients seen at the clinic are covered by Fallon Community Health Plan.

Fallon Community Health Plan has not completed any outcomes studies for the HIV-AIDs program but has concentrated instead on delivering a higher quality of care.

"When you're dealing with quality of care, it's tough to show outcomes. Our prophylaxis rates are consistently high, which is especially important when CD4 T cell levels are low. In addition to focusing on quality, we would like to see the

increase in the cost of medication offset by a decrease in overall utilization," Mlynaryk says.

Like many of Fallon's other disease management nurses, Wesolowski was recruited from the clinic setting and has been working with some of the HIV patients whose care she has managed for many years.

She is the primary contact point for HIV patients and follows an average of 160 HIV patients at a time.

The clinic gets referrals from primary care physicians, local AIDS organizations, or self-referrals from people who have friends who are patients.

First contact

For many patients with HIV, a phone call from Wesolowski is their starting point in getting the health care they need.

When new patients are referred, Wesolowski calls them in advance to answer any questions and invites them to come in for a face-to-face visit with her before their physician appointment.

"We get them in fairly quickly. If they are newly infected with HIV, we try to see them within a week. Often, I can see them within a couple of days and, in many cases, I see them before their physician appointment to talk about the disease and answer any questions," she says.

Some of the patients don't have insurance or have limited coverage. Others are homeless.

"This is a group of people with an illness that has a stigma attached to it. They're not always willing to tell friends and family they have HIV. We try to help them deal with the issue and understand that they do need support," she says.

A diagnosis of HIV is overwhelming for people, she adds. "That's why I like to meet them first and find out their pressing questions," she says.

During the initial meeting, Wesolowski takes a medical history, personal history, and family history from the patient and discusses his or her health insurance and psychosocial needs.

"I can get a complete history and have it ready when they come for their first visit with the physician," she says.

She also can help them get plugged into community organizations that can help with their needs.

Each morning, Wesolowski reviews the list of patients who are coming in for a visit that day, reviews their medications, and makes sure their lab work is up to date and that they have had the inoculations recommended by national AIDS guidelines.

For instance, she checks to make sure patients have had a tetanus shot and their annual flu shots and are current on their pneumonia shots. If the patients are female, she makes sure they have had their annual Pap smear.

Typically, she sees patients with the physicians and does nursing visits on her own for minor problems, such as a sore throat, calling in the physicians when necessary.

She enters all the laboratory work in an intranet-based data registry database that allows her to keep close tabs on the patients' health.

For instance, if a patient's CT4 count falls below pneumonia, she knows he or she has an increased chance of contracting pneumonia and sees to it that the patient is prescribed an antibiotic.

As a quality initiative, she routinely pulls up lists of patients who have CT4 counts below 200 and compares it with the list of medications to make sure all of them are on preventive medication.

A month into the flu season, she checks to see which patients have not yet had their flu and pneumonia shots and calls them to remind them to come in for a shot.

If she notices that someone's virus level is increasing, she pulls up the pharmacy screen to make sure the patient has been refilling his or her medication every month.

"I take a lot of proactive measures with medication. The medications for HIV-AIDS can be extremely complicated. The whole focus here is on people staying healthy, so we make sure they are taking their medications," she says.

If patients don't take their medication correctly or if they miss doses, they are likely to become resistant to that medication, or maybe an entire class of medications, she says.

When the physician prescribes medication for a patient with HIV-AIDS, Wesolowski reviews the medicine, the side effects, and the importance of taking it as prescribed.

She assesses what patients' educational level is and gives them materials in the kind of language they can understand. For instance, if patients are illiterate or have limited reading skills, she uses a series of pictures to describe when they should take their medicine.

She helps them set up pillboxes that will remind them of which medication to take when.

When a patient starts a new medication, Wesolowski calls them a few days later asking if

they're having problems or side effects and how she can help.

She goes over the potential side effects and what can be done about them so the patient will understand what to expect.

Although social work is not her primary focus, Wesolowski can help members locate community services such as transportation, help with housing, or agencies that will deliver meals to their homes.

She keeps a supply of applications for the State of Massachusetts' drug reimbursement program and helps them fill it out.

"I'm very familiar with the social services in the area and can refer people to a program that can help. But I'm only one person, so I can't do everything for them," she says.

Wesolowski has had a face-to-face, ongoing relationship with some of her patients for years.

She is available by voice mail and beeper to her patients and occasionally has been called in the middle of the night when a patient was in the emergency department.

When patients are confined to their homes with hospice care, she makes home visits to check on them.

"I'm not providing care for them; but from a continuity standpoint, I don't want them to think they've been abandoned by Fallon Clinic just because they can't come in," she says.

Wesolowski offers the following tips for other case managers who are dealing with HIV-AIDS patients:

- Network with other case managers and problem-solve together.
- If you have questions, talk to the experts. She recommends the Johns Hopkins Internet AIDS site (www.hopkins-aids.edu).
- Join other organizations such as the Association of Nurses in AIDS Care (www.anacnet.org).
- Plug your patients into community agencies that can help. ■

Pharmacy QI initiative ties in with DM

Program targets members on medication

As an adjunct to its disease management programs, ConnectiCare, a regional HMO based in Farmington, CT, has launched a pharmacy quality improvement program to promote the use of medications that are nationally acceptable treatment standards and to identify and prevent potential drug safety adverse events.

As part of this initiative, ConnectiCare identifies and contacts members who aren't taking some of the medications recommended for their conditions or who have been prescribed medications that might not be appropriate.

The health plan's pharmacy quality improvement committee meets monthly to discuss pharmacy quality issues.

One aim of the committee is to tie together a number of quality initiatives in the organization, says **Jeffrey Casberg**, MS, RPH, director of pharmacy.

"We coordinate our initiatives. For instance, the pharmacy projects go hand in hand with our health management programs. They're not fragmented," Casberg says.

The program has been highly successful, he adds. For instance, the health plan sent out letters to 3,300 members with LDL cholesterol levels at or above 160 who are in the cardiovascular or diabetes health management programs or who are older than 35).

The letters suggested that the members discuss their level with their physician to determine whether they needed pharmacological therapy or whether they might be able lower their cholesterol with diet and exercise.

Nine months later, when the health plan reexamined the data, 58% of those who received the letters had a 20% or greater reduction in cholesterol level.

If an examination of the pharmacy database turns up members in a disease management program who are not filling prescriptions for a particular medication, ConnectiCare sends them a letter suggesting that they talk to their physician about the medication. The health plan follows up with a letter to the physician alerting him or her that the patients may be discussing their medications on their next visit.

The program targets the members themselves, as opposed to sending the mailing to physicians. The letters explain about medication and ask members to bring their letter and discuss the subject with the physician at their next appointment.

"We have found that we are more apt to get a reaction if we send a letter to a member and ask them to talk to their doctors," says **Jay Salvio**,

BSN, MBA, director of ConnectiCare's Health Management department and a member of the pharmacy quality improvement team. "We identify a topic that we feel is important for members to know about and ask them to discuss it with their physician. We send a companion letter to the physician so both of them are knowledgeable about what we want to accomplish."

When the health plan designed the initiative, committee members were careful not to make it seem like they were telling the physicians how to practice, Salvio adds.

"We don't tell the member they should or shouldn't be taking a certain medication. We suggest that they talk to their doctor and have him evaluate it," he says.

The organization started its pharmacy quality improvement program with an initiative to make sure members with congestive heart failure, diabetes, and post-myocardial infarctions were taking ACE inhibitors or ARBs as suggested by clinical guidelines.

The health plan sent out 2,300 letters to members who had the three conditions but were not filling a prescription for the medications. When it did a follow-up study, it found that 21% of members who were not taking the medications had begun taking them following the letter-mailing campaign.

The next step is to identify members who have gotten at least two letters recommending they take a certain drug and finding out why they haven't responded, then decide what initiatives the health plan should take to help overcome the barriers, Casberg adds.

Here's a look at some of ConnectiCare's other pharmacy quality improvement initiatives:

• **Elderly drug safety**: The health plan sends letters to all members older than age 60 who are taking one or more medication that may not be suitable for older people.

"Our letter sends them a list of the Terrible 20, compiled by the General Accounting Office five years ago. We tell them they're on one of the medications and that there may be a better alternative for people in their age group. The letter suggests that the member discuss it with their physician on their next visit," Casberg says.

In 2002, the health plan sent letters to 757 members who were taking drugs not recommended for older patients. When they remeasured, 60% of the 757 members no longer were taking the drug.

The "Terrible 20" includes medications that cause drowsiness and older medications that have more side effects than a similar, newer medication.

"Most are medications that tend to be sedating and put older people at risk for falls and accidents. Some members have been taking the medicines for a long time and simply need to be reevaluated," Salvio says.

• **Aspirin as a preventive measure:**

The health plan has begun an initiative to encourage members to talk to their physician about taking low-dose aspirin as a preventive measure.

The first year, the plan sent a letter to people who had had heart attacks or other cardiovascular events. The second year, it targeted people who could be at risk for an event, such as those with diabetes or those who are older than 50 with diabetes and high lipids.

"While it's well known that aspirin can be helpful in preventing heart disease and heart attack, it's often underutilized. We wanted to get the word out and remind people to discuss aspirin therapy with their physician," Casberg says. ■

Program zeros in on critical times for noncompliance

Patients are treated by primary care physicians

There are two critical times when patients newly diagnosed with depression are likely to stop taking their medicine — the early weeks of treatment and after three months when they start to feel better, says **Laura Schneider**, LSCW, CEAP, manager of assistance programs and the Taking Charge of Depression Program for PacifiCare Behavioral Health.

The health plan's care consultants in the depression program call the members during these critical times to encourage them to keep taking their medication, Schneider says.

"During the first couple of weeks, many people stop taking the medication because of the side effects. After about three months, when they're feeling better, they stop taking it, not realizing that they are more prone to a relapse if they stop taking the medicine too early," Schneider says.

PacifiCare Behavioral Health, based in Santa Ana, CA, is a wholly owned subsidiary of PacifiCare Health Systems. It is a managed behavioral health organization (BHO) providing mental health, chemical dependency, and

employee assistance services to clients that include health plans, union trust funds, employers, school districts, and public sector agencies.

"One of the unique aspects of the program is that it targets patients who are being treated for depression by primary care physicians. Our goals include making sure the patients continue to stay on their medication and supporting the patients and the physicians," Schneider says.

Patients receive three mailings and a minimum of five telephone calls from the health plan's care consultants during the six months they are enrolled in the program. They are encouraged to call their care consultant at any time.

Members are referred by their primary care physician and are contacted by mail and asked to sign a consent form to participate in the program.

The health plan's care consultants call the newly enrolled members and administer the HANDS™ risk assessment for depression. If the HANDS™ score is above a certain number, they transfer the case to a licensed clinician, who does a full assessment and evaluation and handles any emergency situations.

The care consultants repeat the eight-question risk assessment every time they call the members.

"We typically see an improvement in the scores from the beginning to the end of the program," Schneider says.

The BHO sends members materials that include education about depression, the importance of taking their medication regularly, activities that can help depression, such as exercise and dancing, and a booklet for family members.

"Not everything works for every person, so we try to give them information on everything," says Schneider.

The care consultants encourage the members to discuss any issue, including cost of medication and transportation to the drugstore.

"We encourage them to talk to the doctor and to us about anything that may be a barrier to compliance," Schneider says.

For instance, if the member is experiencing unpleasant side effects from the medication, the care consultant can act as a coach in helping him or her decide what to say to the physician.

Members receive a physician visit worksheet with triggers of topics to discuss, such as moods, medication, sleep, and social activities.

"We ask them to write down any questions they have for the doctor and then we walk them through the visit over the telephone," Schneider says.

If the member doesn't feel able to communicate with the physician, the care consultant either calls or faxes the physician and describes the issues before the member's next appointment.

The care consultants help members find community resources that will help with transportation to medical appointments and pharmacies and can help the member locate pharmacies that deliver. They work in the same area as PacifiCare Behavioral Health's employee assistance program team (EAP) team, the people who are most familiar with community resources.

After the final call, PacifiCare Behavioral Health sends out a patient satisfaction questionnaire. There is not a huge rate of return, but the people who do return the questionnaire are positive about the program, Schneider says.

The final mailing describes how to manage a relapse and how to spot symptoms that could signal a relapse.

PacifiCare Behavioral Health started its depression program about three and a half years ago. The original intent basically was to assist any members with depression, whether they had been on medication for 15 years or longer, were newly diagnosed, or called because they were feeling suicidal and needed acute treatment.

"We had a very broad definition of what depression is and what the criteria was. Since it was open-ended, we had a really divergent group of people, which made it hard to measure results," Schneider says.

The behavioral health organization narrowed the criteria and now concentrates on people who are newly diagnosed with depression who have recent prescriptions for medication and are willing to participate in a six-month program.

"We are trying to impact this group and see if we can make a change in the way they feel, how they accept medication, their productivity and functioning within their own family," Schneider says. ■

DM program started with focus groups

Program addresses cardio risk factors

Before Health Plan Alliance started HeartSmart Sisters, a cardiovascular disease management program, the health plan held focus groups to determine what interventions would be most

effective with its targeted group, African-American women.

The program was funded by a Michigan Department of Community Health grant to address cardiovascular risk factors in an urban population, says **Jessica Gubing**, MS, quality management manager for the Detroit-based HMO.

Effectiveness of interventions

HeartSmart Sisters targeted African-American women who had coronary artery bypass surgery, angioplasty, or a myocardial infarction and were between 40 and 70 years old.

"We were particularly interested in looking at secondary prevention of cardiovascular disease in women who have had some kind of cardiac event," says **Patricia Marine Barrett**, MHSA, director of quality at Health Plan Alliance.

The members responded well to the HealthSmart Sisters program. About half of those chosen for the program actively participated in all phases.

In the group that received interventions and had at least one modifiable risk factor, 73% maintained control of one of the modifiable risk factors compared with 66% of the control group who received routine care.

Participants in the health plan's focus groups include representatives from the Detroit Urban League, the NAACP, and members from the targeted population.

"We met with them to get their input on which interventions would be most effective, how they wanted to receive communications, and what types of materials they found most useful," Gubing says.

Members of the quality department designed the program and the materials that supported it based on information they got from the focus groups.

For instance, the written materials sent to participants were based on feedback from the women in the groups.

The women told Health Plan Alliance they preferred information presented in bullet points format. They also said they preferred actual pictures to cartoon-type graphics and wanted most of the people pictured to look like them.

The women chosen to participate in the project were identified through medical review. Because the health plan's database doesn't contain information about race, the team had to review the records individually to find eligible members and to identify some of the clinical indicators for the program, such as blood pressure levels.

Once a group of members was identified, they were divided into two random groups: those who received special interventions and a control group that received routine care.

The program included calls from case management nurses who promoted smoking cessation, weight loss programs, if necessary, and worked with the members to continue taking their medication, make follow-up visits to the physician, and work to improve their own health.

The nurses called the members four times over an eight-month period and gave them a telephone number they could call if they had questions.

Using the feedback from the focus groups, the health plan created brochures on topics such as diet and exercise, smoking, diabetes, hypertension, hyperlipidemia, stroke, coronary artery disease, and diagnostic and therapeutic options.

The brochures were mailed to coincide with the telephone calls from the case managers who went over the material in the brochures.

The participants were asked to take a pre-test before they read the brochures and to take a test afterwards to test their new knowledge.

There was an overall improvement in their scores. The biggest improvement was on the material about diagnostic tests and procedures.

By filling out the tests and returning them to Health Plan Alliance (HAP), the members earned "Continuing Member Education" points, which, in turn, earned them gift certificates to a local department store.

"We feel like they learned a lot from the brochures, so we believe that the format is effective for that population, " Barrett says.

The health plan sponsored diet seminars in the community during which a nutritionist provided ethnically desirable types of recipes that were heart-smart. The participants responded well to the recipes and expressed interest in the seminars but attendance was sparse, Gubing says.

"The seminars were in the community at a central location. The women didn't indicate that the location was a problem. Attendance was not a priority with them," Barrett says.

The case managers assessed the number of risk factors each patient possessed and helped the patient decide which risk factor they were ready to address.

"The case managers reminded them about everything connected to their medical condition and focused on one issue at a time," Gubing says.

The goal most people were able to meet was

lowering their blood pressure. Lowering cholesterol was next followed by stabilizing the hemoglobin A_{1C} levels for women with diabetes.

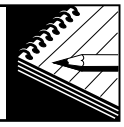
Members who had two modifiable risk factors, such as high blood pressure and weight, and were in the group that received interventions, had a 6% higher rate of improvement that did those in the control group.

Although the funding for the project has run out, the health plan is continuing to offer the brochures to its member. HAP publishes a newsletter for members that included a description of the program and offered support and brochures to people who wanted to participate.

The brochures are being used by case managers in the health plan's cardiovascular disease management program, who send them to members they identify as African-American.

"Because we don't have racial information in our database system, it's a fairly intensive process to obtain information. Until we have a mechanism to routinely identify African-American women at risk, we will be providing the materials upon request to people who want them," Barrett says. ■

GUEST COLUMN



Termination of services: Reaching the end of your rope

How to deal with difficult patients

By **Mindy Owen**, RN, CRRN, CCM
Chair, Ethics Committee, Commission for Case Manager Certification
President, Phoenix Health Care Associates
Coral Springs, FL

Most of us have been there — dealing with the patient who refuses to comply with our treatment plan, who is uncooperative and generally unpleasant. For many of these patients, the stress and strain of their illness, disease, or injury, and the abrupt changes in their lifestyles have proved almost too difficult for them to bear, and it's oftentimes the case manager who gets the brunt of their frustration.

While we've all had a case or cases that we'd rather have passed on, is there ever a truly justifiable case that a case manager can terminate at will? Ethically speaking, no, with the exception, of course, of actual or threatened violence and, in some cases, blatant noncompliance or refusal to follow through with treatment plans.

Furthermore, in addition to the ethical dilemmas these cases pose, there also are potential legal ramifications to terminating a case of which case managers need to be aware. The legal issues involve the potential for liability when case closure is done improperly. Generally speaking, there are eight circumstances in which case management services can be terminated without question:

- Client dies.
- Client relocates.
- Client cannot be located.
- Client is hospitalized, enters a group care facility, is institutionalized, or is not available for services for more than 90 consecutive calendar days.
- Client no longer needs case management services because of changes in his or her condition or circumstances.
- Client refuses services.
- Client requests termination of services.
- Client refuses to cooperate in the provision of case management services.

Termination vs. abandonment

As mentioned earlier, there is always some risk of liability when a case manager terminates services to clients or patients, especially if the client does not agree with the discharge plan, for example. However, there is a distinct difference between *terminating* and *abandoning* a case. Abandonment, of course, is both an ethical and legal quagmire if it is determined that the case was abandoned and not properly terminated.

To ensure that you are staying within both your ethical and legal boundaries, you must protect yourself against appearing as though you are abandoning the client when situations dictate termination. Clients who accuse case managers of abandonment must prove that the case manager terminated the relationship unilaterally, without reasonable notice, and when further attention was required.

In some cases, it is in fact the client who terminates the services through his or her own actions,

albeit perhaps unknowingly or unwittingly on their part. In home care, for example, when clients are consistently not at home for scheduled visits, the clients themselves are terminating the relationship. In such cases, always leave a written note indicating that the appointment or visit was missed and document this in the client's records. You must notify these clients who are unavailable for a specified number of visits that they are constructively terminating their relationship with you and your facility or agency.

In most organizations, a limit of two or three missed appointments is warranted to discharge the client from your services. Afterward, follow up with a written notice to the client that his or her case is closed, document the discharge in the client's medical record, and notify the physician.

Keep in mind that when clients terminate relationships directly with providers and everyone involved in the client's case agrees to the termination, the providers have no liability.

Termination issues

Termination of services gets more ethically challenging in those cases in which the client's insurance no longer covers your services. In these cases, you can first suggest that the clients pay privately, even if you think they have no other resources. Document the offer and the client's response. If the client declines to make other payment arrangements, it is the client who is terminating the services.

And finally, perhaps the ultimate ethical challenge: those clients suffering from mental illness or poor judgment, limited financial resources and no available, willing, or able caregiver. Without your services, the client may suffer injury or further declining health. One way to approach the situation is to have a meeting or conference with the professionals who are part of the treatment team to develop a service discharge plan. This most likely will involve a community resource, such as adult protective services. A realistic discharge time frame is two to three weeks.

In many of these cases, you may need to arrange for transportation for the client if the discharge plan calls for a change in the client's setting. Should the client refuse any of your services or interventions, it is the client who is terminating your services. Document your discharge plan and the patient's response to all recommendations and interventions.

Documentation holds the key

As with all of the duties you perform, documentation is key to protecting yourself and your employer should disputes or questions about your actions arise. In cases of termination, documentation is especially crucial.

Keep these tips in mind when proceeding through termination steps:

- Print neatly with black ink. Black ink photocopies best.
- Identify the time and date on every progress note and sign the entry with your title.
- Document all teaching performed and instructions provided to the client and/or caregiver and always include their responses.
- Be factual and specific in all documentation.
- Do not discuss agency problems or staff issues in a client's note.
- To correct any errors or mistakes in your documentation, do not attempt to erase or blot it out. Instead, draw a thin line through the documentation and write "mistaken entry" above it and sign your initials over it.
- Never completely cover a mistaken entry.
- Document all telephone calls, e-mails, and any other communications with physicians, community agencies, and other team members. This should include explanations of what occurred with the patient, what actions were ordered and taken, how they were implemented, and the outcome of those actions.

This may be a difficult and uncomfortable situation for you as a case manager. Your goal is to do your best to keep your patient from harm; however, you need to protect yourself as well. Taking the right steps and documenting the process will protect you and the clients you serve. ■

CE questions

11. Since HealthPartners started its outpatient case management program, the per-member-per-month cost for patients in the program has dropped by:
A. 10.2%
B. 60.8%
C. 48.3%
D. 24.7%

12. Duties of the case manager in Fallon Community Health Plan's HIV-AIDS management program include:
A. Meeting face-to-face with patients in the program
B. Monitoring patients' labs and medications
C. Assisting patients in finding community resources
D. All of the above

13. ConnectiCare's pharmacy quality improvement initiative promotes use of medications within nationally acceptable treatment guidelines and targets the members instead of the physicians.
A. True
B. False

14. According to PacifiCare Behavioral Health Management, the two times patients are most likely to stop taking their medication for depression are:
A. After a month and after a year
B. During the first few weeks and at the three-month mark
C. The first two times the prescription is refilled
D. At three months and one year

15. Participants in focus groups that lead to Health Alliance Plan's HeartSmart Sisters cardiovascular management initiative said they preferred printed materials with the following kinds of features?
A. Cartoons and big type
B. Photographs of doctors and nurses
C. Bulletpoints and realistic-looking pictures
D. Simple language and lots of drawings

Answers: 11. D; 12. D; 13. A; 14. B; 15. 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™

CDC recommends smallpox vaccine for monkeypox

The Centers for Disease Control and Prevention (CDC) has issued guidance advising states that hospital workers and others caring for patients infected with the monkeypox virus and close contacts of people or animals confirmed to have the virus should receive a smallpox vaccination to protect against the possibility of contracting the illness. They can be vaccinated up to 14 days post-exposure, the agency said.

At a June news briefing, CDC deputy director David Fleming said the vaccine is roughly 85% effective in stopping monkeypox. The CDC currently is investigating 54 possible human cases of the virus in four states: Indiana, Wisconsin, Illinois, and New Jersey.

The CDC also has posted a case definition for human cases of monkey pox at www.cdc.gov/ncidod/monkeypox/index.htm, and the Department of Health and Human Services has enacted a ban on the importation of all rodents from Africa. Health officials fear the imported animals could further spread monkeypox throughout the United States. ▼

OSHA proposing revised respiratory standards

The Occupational Safety and Health Administration (OSHA) has published two proposed rules in the *Federal Register* to enhance worker protections from respiratory hazards on the job. OSHA is seeking comments until Sept. 4, 2003, on its proposals to amend the Respiratory Protection Standard to include a new fit-testing procedure and incorporate new Assigned Protection Factors (APFs) for respiratory protection programs, that are expected to prevent approximately 4,000 injuries and illnesses and about 900 deaths annually from cancer and other chronic diseases.

"It's critical that workers and employers select respirators that will protect users against overexposures and adverse health effects," said OSHA administrator **John Henshaw**, in making the announcement. "These proposed additions will assist employers and employees in fit testing respirators and properly selecting respirators based on the conditions in their workplaces."

In a notice of proposed rule making, OSHA will propose amending the existing Respiratory Protection Standard to incorporate Assigned Protection Factors (APFs) as part of a complete respiratory protection program to assist workers and employers in the proper selection of respirators.

APFs are numbers that reflect the workplace level of respiratory protection that respirators are expected to provide to employees. The proposal contains OSHA's preliminary decisions on an APF Table, definitions for APFs and Maximum Use Concentrations, and amendments to replace the existing APF requirements in OSHA's substance-specific standards.

OSHA also is seeking comment on its proposal to approve a new testing protocol for its Respiratory Protection Standard. The proposed protocol is referred to as controlled negative pressure (CNP), which requires three different test exercises followed by two re-donnings of the respirator.

OSHA's current CNP protocol specifies eight

test exercises, including one re-donning of the respirator.

Written comments on both proposed rule makings must be submitted by Sept. 4. Written comments (10 pages or fewer) can be faxed to OSHA's Docket Office at (202) 693-1648 or sent electronically to http://ecomments.osha.gov. Three copies of written comments and attachments must be submitted to the OSHA Docket Office, Docket H-049C (APF) or H-049D (CNP), Room N-2625, U.S. Department of Labor, 200 Constitution Ave., Washington, DC 20210.

Further information on submitting comments can be obtained by calling the Docket Office at (202) 693-2350.

OSHA plans to hold an informal public hearing on the APF proposal in Washington, DC, in late summer or early fall of 2003. Interested parties who intend to present testimony at the hearing must notify OSHA of their intention to do so no later than Sept. 4. The meeting location and date will be announced following the comment period.

For more information, visit www.osha.gov. ▼

CMS: 3.3% rise in home health payment rates for FY 2004

The Centers for Medicare & Medicaid Services (CMS) announced a 3.3% increase in Medicare payment rates to home health agencies for fiscal year 2004. The increase will bring an extra $340 million in payments to home health agencies next year. Home health payment rates are updated annually by the percentage change in the home health marketbasket index. CMS establishes the home health marketbasket index, which measures inflation in the prices of an appropriate mix of goods and services included in home health services. The updated payment rates are published in the July 2 issue of the *Federal Register*.

In addition, on June 16, CMS launched "Home Health Information Resource for Medicare," a new on-line tool for home health agencies (HHAs) that's available on the CMS web site. The resource center provides a comprehensive database that includes information on enrollment and participation, initiatives, policies and regulations, coding and billing, Outcome Assessment and Information Set, research, education, preventive services, program integrity, and Medicare secondary payers.

The web site also gives HHAs information for staying on top of the home care industry, with sections on the latest news and where to find it, home care contacts, and home health highlights. CMS created the page to "incorporate all home health-specific information in one place" and will update it regularly. To access the site, go to: www.cms.hhs.gov/providers/hha. ▼

No quick end to nursing shortage, new report says

Although health care organizations are using innovative strategies to recruit and retain nurses and federal, state, and local government agencies are providing financial support to help alleviate shortages, the national nursing shortage will continue to be one of the greatest challenges to the health care industry for many years, according to a report issued by Fitch Ratings, an international credit rating agency based in New York City.

Because health care providers will continue to experience salary inflation and increasing benefit expenses, these costs will offset any savings from increased operational efficiency in other areas.

The "Nursing Shortage Update" report can be found at www.fitchratings.com. Click on "U.S. Public Finance," then "Special Reports." ■

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.

Send items for publication to Mary Booth Thomas, Editor, *Case Management Advisor*, P.O. Box 740056, Atlanta, GA 30374. Phone: (770) 934-1440. E-mail: marybootht@aol.com.

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