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Proactive interventions cut hospitalization rate dramatically

Program targets at-risk members

Since Harvard Pilgrim Health Care, based in Wellesley, MA, started its Health Advance care management system to intervene with at-risk members before they require intensive medical services, the hospitalization rate for members in the program has been cut in half.

In an eight-month period before the program started, members who qualify for Health Advance care management experienced a hospitalization rate of 16.73%. After the program was implemented in August 2001, members who participated in the program experienced an 8.32% hospitalization rate.

Based on the results to date, the health plan anticipates that Health Advance will deliver significant decreases in hospital days and a reduction in per-member, per-month costs of 20% to 25% for members participating in the program, says **Liz Estabrook**, RN, manager of care management for the health plan, which covers more than 800,000 members in Massachusetts, Maine, and New Hampshire.

Harvard Pilgrim Health Care uses a predictive modeling software application from Status One, a health management services company based in Westboro, MA, to identify at-risk members who typically have multiple chronic diseases and comorbidities and psychosocial needs.

"By intervening earlier, we can dramatically influence the health and well-being of this member group which, while very small in number, represents a high percentage of medical costs," Estabrook says.

The health plan has estimated that 0.5%-1% of the total membership accounts for 30%-40% of all inpatient days and 20%-30% of medical costs.

"We target members who are likely to have a hospital admission in the next year, based on their utilization history. These are members whose condition will get worse if they continue on the path they are on," Estabrook reports.

The original goal was to have a Health Advance care plan in place for at least 70% of the identified members. The actual figure is closer to 95%, with dramatic results, such as the decrease in hospitalization rates

for members participating in Health Advance, adds **Roberta Herman**, MD, chief medical officer.

"Care for at-risk members is often uncoordinated and fragmented across multiple specialists, and they may not be well known to their primary care physicians. We work with our members' care providers and families to create a patient-specific care plan designed to reduce the level of illness and improve daily living," she adds.

The Health Advance nurse care managers are highly experienced generalists who are trained to work with patients, no matter what their diagnosis.

They are assigned to members by geographic areas so they can be familiar with resources in the community and can develop a relationship with physicians.

The Health Advance nurse case managers work in tandem with the disease management team to coordinate care for patients who may qualify for one or more of the health plan's disease management programs.

"Since these patients have multiple conditions, the Health Advance nurses take the primary responsibility for their cases," Estabrook adds.

For instance, if the Health Advance nurse care manager is working with a complex diabetic who needs a lot of education, he or she collaborates with the diabetes disease management nurse. The disease management nurse may provide the educational materials but leave the actual interventions to the Health Advance nurse.

A member who needs help managing only diabetes wouldn't be in the Health Advance program.

"We definitely try to avoid having multiple people calling the same member," Estabrook says.

When the program started, a number of people already in the disease management program were shifted to the Health Advance program if they had multiple conditions.

"We evaluated the cases as we went along. If somebody was already in a close relationship with a disease management nurse, we might make an exception. We didn't want to interrupt a relationship if the member was making good progress," she says.

The nurse case managers are assigned 10-15 new cases a month. They receive a complete utilization history, including what kind of hospital visits or outpatient visits the member has made and medications the member has been prescribed.

During the first call, the case managers get the patient history, determine how much the members know about their illness and medication, and answer any questions about the program or the members' conditions.

"We work on building a relationship from that first phone call. The Health Advance care managers act as a coach and help the members feel comfortable and confident about managing their own disease," Estabrook says.

They work with the members to set goals and help them learn how to manage their own health. **(For details on how the program works, see related story on p. 135.)**

The care managers collect clinical information from the member's primary care physician and use the information to determine the member's acuity level or potential for hospitalization in the future.

The acuity level determines how sick members are and how frequently the case manager will call

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Editorial Questions

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

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them. The members are encouraged call the care manager in between calls if they have questions or concerns.

As the members build self-reliance and are able to take more responsibility for their own health care, the nurse case managers may move them to a lower acuity level and begin working with them less frequently.

"When they have their conditions more under control and moving in the right direction, we tell them that we feel like they can continue the process on their own," Estabrook says.

Members stay in the program an average of six to nine months.

When members are discharged from the program, the care manager lets them know that they can call any time in the future that they feel they need help.

If they are hospitalized again or their risk assessment changes, they automatically are put back into the Health Advance system. ■

Program helps members take control of their health

Goal setting, personal responsibility are keys

Involving members in goal setting and getting them to take personal responsibility for their own health are keys to the success of Harvard Pilgrim Health Care's Health Advance Care Management system, according to **Liz Estabrook**, RN, manager of care management for the Wellesley, MA-based health plan.

"From the beginning, we try to get the members engaged in the process. We try to get them to take some ownership by looking for the information they need," Estabrook says.

The care managers work with the members to set goals. They may be clinical, such as lowering their hemoglobin A_{1c} level, or personal, such as being able to play golf or spending time with their grandchildren.

"We don't say 'Do A, B, C, and D.' We know that if we go in there with a prescriptive approach, it is likely to turn the person off. Instead, we make suggestions and ask the member if they feel comfortable trying something. We try to make sure the member is ready," Estabrook says.

Members are more likely to meet goals when they help develop them, she adds.

Many of the members don't understand what their laboratory tests are or why the results matter. They just know their doctor says the results are too high or too low. That's one reason that setting goals involving lab values don't always work.

"From the nursing perspective, our goal is to get the hemoglobin A_{1c} down, but the member's goal may be something else. You have to have buy-in to get someone to change, and that's why it's critical to build that relationship to find out what motivates the member and what their goal really is," Estabrook says.

As members progress toward meeting their personal goals, the lab results will improve, she adds.

"It's human nature that when someone tells you to do something you resist, and what we think the member should do isn't always the best fit. We work with the members about what things they'd like to do to get their chronic conditions under control," Estabrook notes.

For instance, one member with chronic obstructive pulmonary disease wanted to be able to go out to lunch with friends but was too debilitated to make the effort.

The care manager worked with him on an exercise program and taught him about the disease process and how to conserve his energy.

Many of the members in the program are employed but have conditions such as diabetes that are not quite in control.

"We try to work with them to give them an incentive. For instance, if they can control their diabetes better, they might have more flexibility in their diet. We show them how one thing impacts another thing," Estabrook says.

The care managers get the members involved in taking care of some of the details necessary to meet the goals.

For instance, if a member says he is ready to try to lose weight, the care manager tells him where he can find a suitable diet and says she'll call back in a week or so and review the diet with the member. She may suggest a consultation with a dietitian or suggest that the member talk to his primary care physician about a diet. If the care manager calls back and the member hasn't found a diet to try, the care manager talks with him about the reasons he hasn't done it.

"We might have to rethink the plan and come up with an alternative goal. It might really not be convenient for the patient to find a diet, and we'll send it to them. Or they might have said they were ready to lose weight but they aren't quite

ready," she says.

The Health Advance care managers gradually move the members in the direction of change, coaching them toward their goal.

The care managers give members the responsibility for following up with their physician and helping gather information for the care management database.

For instance, instead of calling the physician for a report on a member's visit herself**,** the care manager has the member collect the laboratory information and other results.

"We assist members in managing their own health as opposed to managing it for them. When people are responsible for handling it themselves, they are more likely to follow through," she says.

The Health Advance care managers build a relationship with the members and don't push them to make changes until they are ready.

"We are building a trust and a comfort level. As they are more comfortable with the discussion and feel more confident about changing their lifestyles, they start to work on their goals," she says.

The Health Advance care managers do little extra things for the members as well, such as helping them with their benefit question so they don't have to call another number.

"We do a little piece and they do a little piece," Estabrook says. ■

Social work CMs help members connect

They work as adjunct to case management

The publicly insured members covered by Horizon-Mercy often have psychological and social needs along with their medical conditions. To better serve these needs, the Trenton, NJ, health plan for the publicly insured started a social work program in May 1997.

The program is staffed by certified and licensed social workers and a social work outreach staff that assist with follow-up such as reminding members to go to appointments and helping connect the members to services.

Staff have received extensive training and alert the social workers if it appears that the member needs more assistance.

"The Medicaid population has needs that are so different from those of people covered by commercial health plans. They are close to the poverty line and have extensive psychosocial needs in addition to their need for medical care," says **Irma Alicea**, LCSW, manager of the social case management department.

The social case managers are assigned by region and by county, so they are experts on all the resources and programs in the areas they cover. They work closely with the nurse case managers who cover the same areas.

The nurse case managers and social work case managers get together frequently and discuss the members who have complex needs and care plans. A medical director is always present.

The social workers advocate for the members and make sure they are tied in with the community and other state and federal programs that are available to them. The social workers help remove barriers that may hinder medical adherence.

For instance, if a Horizon-Mercy member is homeless, the social worker directs him or her to a housing assistance program and helps the member connect with community organizations that can provide food and clothing and/or help with transportation needs.

"We work with the members on problem-solving skills and empowerment. We want them to be aware of all the resources available to them and to educate them on how to access the services so they are not dependent on the social workers," Alicea says.

Social workers are called in when there is a crisis in the family, such as a seriously ill family member who might have social needs.

"We are working with families living on the edge of poverty as well as other dynamics related to poverty," says **Rita Brown**, LCSW, senior social case manager. "We understand the effect a serious disease can have on a family, whether it's an older couple or a family with young children. We use our clinical skills in this kind of crisis situation to assist the member in getting involved with community services, therapy, or a support group, as well as helping them with needs such as food and shelter and helping them become the owner of their care plan."

The health plan has contracted with taxi companies to drive members from one point to another at a fixed rate for medical appointments. In cases of medical necessity, an ambulance transports members.

When new members join the plan, the intake coordinator does an initial assessment and alerts

social work if the family needs its services.

The social workers have an active caseload of between 80 and 100 clients at any given time, reports **Mizuki Ogawa-Peterson**, LSW, social case manager.

Working with members

Most of the social work clients also are being followed by a Horizon-Mercy case manager in another department who helps with their medical needs. The social work case managers are called in only when there is a psychosocial issue.

"When the client's basic psychosocial needs are met, we close the case but make sure they know that we are always available. I've closed and reopened some case many times," Ogawa-Peterson adds.

One member, who lost her private health insurance when she was laid off from a Wall Street firm, developed a severe heart problem. When she didn't go to her doctor's appointment, her social worker found out that she didn't have money for transportation.

The social worker arranged for the hospital to pick her up in a van. The member participated in a clinical trial. A few months later, the woman called to say she was well enough to drive herself to the physician.

The social work team is alerted any time a member needs psychosocial services. The call may come from a provider, a community organization, a Horizon-Mercy nurse case manager, or the members themselves.

For instance, a provider called Brown about a newborn member with a rare disorder.

"The family was very proud and resistant to any help from social agencies. They had a child with a serious medical condition and were living on the kindness of relatives," Brown says.

She persuaded the mother to apply for Social Security Supplemental Security Income (SSI) benefits for the child and helped the mother find a nearby food pantry.

"It's a win-win situation. The child is getting the care he needs. The SSI income gives the family a stable amount of income," Brown says.

Some of the members are from working families and have another form of insurance but family members qualify for Medicaid because of special needs, such as a child with cerebral palsy or mental retardation, reports **Sherri McPherson**, CSW, senior social case manager.

"These are truly medically ill members. We become the secondary insurer, but we still monitor them and provide social work case management to assist them in identifying resources that are available for them," she says.

Many members move around frequently, and the social workers sometimes have to track down their whereabouts, particularly in case of a medical crisis.

"A social worker is sometimes a bit of an investigator as well. When we really need to get hold of other members, we use the state Medicaid system as a resource but also call people who may have a connection with the member and track them that way," Brown says.

For instance, Alicea was contacted by the physician of a pregnant member whose tests showed a serious medical condition and who could not be contacted by telephone.

Alicea knew from talking to the woman that she was homeless and had been staying in shelters, so she started calling all the shelters until she found her.

A social worker visited the shelter early the next morning, arranged for care for the woman's younger child, and got her back to the hospital.

The Horizon-Mercy social work team is very diverse, with more than half of the social workers and outreach staff speaking at least two languages.

Being bilingual and understanding other cultures is invaluable, says Ogawa-Peterson, who is Japanese and recently worked with a Japanese man with severe diabetes.

"He had been admitted to the hospital several times; but because of language barriers and cultural differences, he did not follow medical advice. He wasn't able to care for himself and would not seek the help he and his family needed," she recalls.

The wife had not been able to get help from social agencies because of cultural and language barriers.

Ogawa-Peterson worked with the family, gradually building trust and rapport. She helped the family apply for welfare and got disability for the wife. The man began following his treatment plan.

"He still suffers from diabetes, but he is more medically stable, and the family is getting the services they need," she adds.

The health plan has social workers who visit members in the hospital and has started a pilot project that locates social workers in the emergency department of a large hospital.

"When they are in the hospital or emergency

room, the social worker sees them face to face and can assess for their needs, educate them, and help them get the services they'll need when they are discharged," Alicea says.

When the members are admitted into the hospital, the social worker assigned to that particular hospital is notified.

"We do outreach, education, and follow up with the primary care provider and send out letters to the members reminding them to go back to their physician," she says. ■

Initiative helps health plan beat national averages

Self-management, physician incentives are part

A comprehensive asthma management program has paid off for Care Choices HMO of Farmington Hills, MI. The health plan received the "best-in-class" designation in the National Committee Quality Assurance's Quality Compass 2003 report in appropriate use of medications for people with asthma, ages 5-9, and was listed as No. 1 in Southeast Michigan and 10th in the nation in use of appropriate medication for people with asthma in all ages.

The comprehensive program includes self-management support for all members with asthma; case management and collaboration with practitioners on individual care for at-risk patients; and physician reminders and physician incentives that support appropriate asthma management.

"A number of factors contributed to Care Choices clinical performances, including outreach, education, and care management incentives. Since we began our programs for diabetes and asthma, we have seen an improvement of more than 10 percentage points in key quality-of-care measures. Committed and involved physicians are the key to attaining such results," says **Gilbert Burgos**, MD, MPH, chief medical officer of Care Choices.

For instance, for members ages 5-56 years with persistent asthma, 77.72% of Care Choices members were prescribed appropriate medications in the past year, compared with the national average of 67.93% and 67.72% for Care Choices in 2001.

Care Choices began its asthma program in 1999 after an analysis of utilization data and performance rates identified that as a priority area, says **Linda Hayden** RN, BSN, project manager in the medical affairs division for Care Choices.

Members are placed in the Care Choices Asthma Registry if they have four ambulatory visits for asthma in a 12-month period, fill a prescription for asthma medications four times, or have one inpatient or emergency department (ED) visit for asthma.

All members who meet the criteria get population-based information on asthma self-management, including direct mailings, newsletter and web site articles, and Internet links that address the components of appropriate asthma management.

Members who have utilized the ED or had an inpatient admission for asthma are referred to case management for evaluation, Hayden says.

Patients also may be enrolled in the program upon physician recommendations or if they call the plan's toll-free health line and request it.

Care Choices utilization managers may recommend someone for case management if they don't quite meet the criteria but need help managing their asthma, Hayden says.

The plan has works with a hospital-based utilization nurse and case manager who notify the Care Choices case managers when a member is hospitalized or treated in the ED for asthma.

"Coordinated care is an important issue, especially with emergency room visits and inpatient admissions," Hayden says.

The plan encourages patients to follow up with their primary care physician within a week of an ED visit or inpatient admission.

"It takes a team of people to develop and implement a comprehensive disease management program. The Care Choices team includes member benefits, nurses, physicians, pharmacy, marketing, community programs and linkages, and information system. A physician champion is very important to support and promote the program and ensure the physician and member educational information is clinically correct," Hayden says.

A key component of the asthma management program is a quality incentive program that rewards physicians financially when they work closely with their asthma patients to ensure that they are taking their medication properly.

Care Choices tracks medication usage in its members with asthma and sends a monthly "Quality Incentive Report" to primary care physicians identifying each of his or her patients who had one or more short-acting bronchodilator

prescriptions filled in a six-month period.

The purpose of the report is to help the physician monitor the use of short-acting medication, identify patients who are at-risk, promote physician follow-up, and encourage the use of long-acting medications when appropriate, Hayden says.

The primary care physicians receive a financial incentive payment based on the number of patients who refilled a prescription for a short-acting bronchodilator fewer than three times in a six-month period.

"The quality incentive initiative helps us identify at-risk individuals, it helps promote follow up by the physicians, and it encourages the use of long-acting medication rather than short-term rescue medication," Hayden says.

When an at-risk member is referred to case management, the Care Choices case manager contacts the member's primary care physician.

Then the case manager contacts the member, conducts an asthma survey, and begins working with the member to establish goals supported by an asthma action plan that includes using the appropriate medicines and the appropriate time and following up with the physician.

The asthma action plan is an individualized management guide that describes how to treat and control asthma, whether the member is experiencing symptoms or not. It may include asthma signs and symptoms, steps the patient should take when peak flow meter measures reach a certain level, medications, and a list of triggers.

The case managers and the members work together to develop mutual goals. Goals may be appropriate medication management or following up with physicians.

Other goals may be getting immunizations for flu or pneumonia or cutting out exposure to second-hand smoke.

"We are trying to provide a comprehensive means of addressing at-risk individuals. We try to tie them into other programs. For instance, we have a free stop-smoking program that has an excellent quit rate. If the member doesn't smoke but is exposed to second-hand smoke, we raise that issue as well," Hayden says.

The program is tied in with other Care Choices programs, such as a program to increase adult immunizations for flu and pneumonia and a community-based asthma education program that provides face-to-face, one-on-one education such as instruction on using peak flow meters and when to use what medication.

The frequency of follow-up contacts is individualized based on the needs of the member.

"We assign our case managers by geographic area so there is a consistent message approach provided to physicians and to patients," Hayden says.

When the members meet their goals, they may not receive one-to-one contact from a case manager but they remain in the registry and receive the educational information at regular intervals.

"With asthma, some seasons are worse than others. It is a chronic disease, and we want to assure appropriate self-management," Hayden says.

Care Choices participates in the Michigan Quality Improvement initiative, a collaborative effort that develops consistent evidence-based clinical practice guidelines that all health plans send to physicians.

"It was a barrier for physicians to receive a number of different guidelines from the different health plans. We have worked to develop and implement one set of evidence-based guidelines for various conditions, including asthma," Hayden says.

When the plan sends out a mailing to members with asthma, it sends the same mailing to the physicians so they can be prepared for inquiries.

Physician office staff are included in the educational process.

"We have found out through experience how important it is for the physician's office to be educated about chronic diseases. We provide asthma educational materials to the office staff and the nurses as well as the physicians," Hayden says.

The plan studies its data on an annual basis and looks for what works well and what doesn't. "We do a barrier analysis to find out what is working well and used trends to try to improve," she says. ■

New approach helps members manage disease

Program integrates DM, decision support

Independence Blue Cross takes a three-pronged approach to helping members manage their health care with its newly expanded Connections℠ Health Management Program.

The program uses specially trained clinicians, called health coaches, who help members to better

understand and manage their chronic diseases, and make effective choices with their physicians when they are faced with a health care decision. They also answer questions about everyday medical concerns.

"We believe our program is on the leading edge because of its scope and integration. The program covers all five major chronic diseases, and it integrates disease management and decision support," says **Esther Nash**, MD, senior medical director of the Philadelphia-based health plan.

The health plan has been providing population-based disease management and disease-specific case management since the early 1990s and has dramatically expanded the services this year, she adds.

"The program offers something for everyone — patients who have a chronic condition, those who are facing an acute problem, and people who have everyday health concerns," Nash says.

The disease management component provides support services for members with five chronic conditions: asthma, chronic obstructive pulmonary disease, coronary artery disease, congestive heart failure, and diabetes.

A proactive approach

The health plan estimates that members with those ailments account for 24% of medical costs for the commercial products and 55% of medical costs for Medicare products. More than 33% of its Medicare population has at least one of the five chronic diseases.

"There is evidence that people who participate in a program like Connections can change their behavior and experience fewer complications and hospitalizations due to their medical conditions, improving their quality of life and lowering overall health care costs," Nash says.

Members who are facing serious health care decisions, such as whether to have back surgery or what to do concerning newly diagnosed breast cancer or prostate cancer, can talk to the health coaches and get information about various treatment options and how to discuss their options with their physicians.

"This program is designed to help members increase the quality of their health care by taking a proactive approach to their conditions," Nash adds. "Knowing the right questions to ask and then partnering with a physician to make the right care decisions is an important part of quality care."

Members who have everyday medical concerns or questions can call a health coach with questions and receive educational materials mailed to their home or through the Healthwise Knowledgebase on the Internet.

"Integration is one of the major strengths of the program," Nash comments.

The health coaches use a system that tracks all the interventions anyone has with the member.

The program is integrated with other health plan medical management programs such as weight loss and fitness programs, intensive case management, concurrent review, and pre-certification, through an extensive database.

All of the health coaches are licensed clinicians. Most are RNs, but nutritionists and respiratory therapists also serve as health coaches.

In addition to training in the targeted clinical conditions, the health coaches go through training in patient engagement, recognizing behavioral cues, and shared decision-making techniques.

"This underlines the decision support this model provides. When we are faced with medical decisions, all of us as patients can make the best decision when the decision making is shared between doctor and patient," Nash says.

The patient engagement training helps the health coaches understand that patients may be in different places psychologically at different times and under different circumstances. The health coaches learn to recognize behavioral cues while they are talking with the members so they understand the most effective way to approach the member, she adds.

The health coaches are cross-trained in all three components of the system so that the same health coach deals with the same members no matter what their needs. When a member needs additional help from a specialist, however, the RNs can call in the respiratory therapist or nutritionists for a consultation.

"We place a value on the personal health care relationships. It's important for the member to know the name and direct phone number of their personal health coach rather than being referred around," she says.

When members are identified for the chronic conditions program, the health coaches customize the intervention schedule to meet the needs of each patient.

The health coach and member set goals based on medical evidence. For instance, if medical evidence has shown that people with congestive heart failure benefit more from being on an ACE

inhibitor than from having another intervention, the health coach makes sure that ACE inhibitors are the first topic covered with the member.

"There is only so much you can cover in a 30-minute call. What comes up is prioritized, and it's different for each patient, depending on what condition and what combination of conditions they have," Nash says.

The program was purposely designed to be without an endpoint.

"We may decrease the frequency of outbound calls and re-stratify the member, or they may move from being telephoned to getting mailings. The only way members leave the program is to voluntarily opt out or to leave the health plan," she says.

The health plan uses medical and pharmacy claims, utilization information, laboratory results, and risk assessment data to identify members who may benefit from the program. All members receive information on how to access the program. Higher-risk members are called by the health coaches, who discuss the program with them individually.

For the decision support component of the program, the health plan looks for patterns in claims and admissions data to determine when a member may be facing a major health care decision.

For instance, there may be a patient who had an orthopedic consultation, followed by three months of physical therapy, visits to a chiropractor, and an MRI of the back.

"This trail of interventions makes it highly likely that the member may be facing a decision about back surgery," Nash says.

In that case, the health plan would send the member information reminding him or her of the decision support services.

"Our philosophy is that the best time to get information into the hands of the member is early in the treatment process, before they have made a decision to schedule surgery," she adds. "We repeatedly take steps over time to make members aware of these services, in hopes that they will call us even if we haven't yet found them. We make the doctors aware of the services so they can refer patients as well," Nash reports.

When the plan launches the program for a new segment of its population, all members receive a refrigerator magnet reminding them of the services.

"They may not need it the day the mailing comes in, but our goal is to keep their awareness high so they can call in whenever they feel a need," Nash says.

Members receive regular mailings about the program and may call in and ask to participate. The plan has informed physicians about the program, set up a hotline number for physician questions or referrals, and has provided physicians with referral cards for patients they think will benefit from the program.

The health plan rolled out its program by phases, starting with the Pennsylvania Medicare population on July 1, followed by preferred provider organization-insured members in Pennsylvania in October. The program will be available in January to commercial HMO members and self-funded employers.

It will be more than a year before Independence Blue Cross has outcomes data to demonstrate the effectiveness of the program, but already there are indications that it will be a success, Nash says.

All members who are identified for the chronic disease management program have an opportunity to opt out, but less than 1% have chosen to do so.

Members have reported that they like the program, and usage rates are high.

When the program was rolled out to the Medicare population, the health plan set up a comment line where members could call with comments about the program. So far, out of 70 calls received, 69 were overwhelmingly positive and the other was a misdirected call. ■

Collaboration helps get members back to work

CM, vocational rehabilitation work together

Through a team approach that involves case managers, vocational rehabilitation counselors, and on-site job coaches, CIGNA Group Insurance has developed a successful return-to-work program for members who are severely injured or experience debilitating illnesses.

"Our vocational rehab staff works very closely with case managers to help establish return-to-work plans and goals. It's a very successful approach that we've been using for some time. We identify early on those claimants who are likely to need vocational rehabilitation and move them along the continuum to get them the services they need," says **Angelica Greene**, MHS, CRC, manager, vocational expert resources for

CIGNA Group Insurance in Pittsburgh.

The process of getting injured or seriously ill members into the vocational rehabilitation program begins with the first telephone call from a case manager.

"Within the first week that the claim arrives, the case managers get in touch with someone. It may be the claimant or their physician or their employer, depending on the patient's condition. In many cases, the contact is with all three," Greene says.

When the member is ready to look at return-to-work options, the case manager alerts the telephonic vocational rehabilitation counselor.

Later on, if the member needs face-to-face services, such as job coaching or someone to visit the work site to look for job accommodations, a vocational counselor from Intracorp, a CIGNA subsidiary, is alerted.

The case managers and nurses working with the patients on a day-to-day basis start discussing vocational rehabilitation services with the members as soon as they are stable.

"They keep us informed about the claimant's ability to work so that when we start talking with the employers, we are aware of the claimant's level of functioning and we have something to work with," Greene says.

As treatment progresses, the nurse case manager, vocational rehabilitation counselor, and claims case managers all work together as a team to see that seriously ill or injured members get the services they need.

"When you're looking at someone on the road to recovery who is going to be going through physical and mental rehabilitation, vocational rehabilitation should be part of the plan from the outset," Greene adds.

One vocational rehabilitation counselor covers the cases handled by one long-term disability team that typically is made up of 10 case managers.

The vocational rehabilitation counselors and nurse case managers are located in the same office with a conference table in the middle of the room that they can use for team meetings.

"Their proximity alone helps with the communication and the timely transition of cases to the vocational rehabilitation counselor. They have daily case management sessions, both formal and informal," Greene says.

For instance, the case managers alert the vocational rehabilitation counselors when they feel a client is ready for return-to-work services and discuss what issues and obstacles they may face.

The nurse case manager, physician, and vocational rehabilitation counselor decide when a member is medically stable and ready to be turned over to vocational rehabilitation.

The frequency of the team meetings depends on the needs of the individual cases. Typical meetings may be weekly for short-term disability cases and bimonthly for long-term disability cases.

When a member is nearing return to work, the case managers, vocational rehabilitation counselors, and other involved parties — such as the employer or the state rehabilitation commission — are in touch more frequently.

"We have open, ongoing sessions with the entire team and often include physician advisers as well," adds **Rose Marie Antonucci**, MS, CRC, CCM, LPC, vocational rehabilitation counselor with CIGNA Group Insurance.

"The nurse case manager looks at the claimant's progress, and whenever it looks like stability has been achieved and the claimant is moving nicely along, they present the case to the vocational rehabilitation counselor," Antonucci says.

Patients who are turned over to the vocational rehabilitation counselors have been seriously injured or have a debilitating illness and are on long-term disability.

The vocational rehabilitation counselors work with them over the telephone, helping them get back to work.

"We work to get an individual back to work doing a job that is most similar to the individual's work experience. It may be the same job or a different job with the same employer or, if that can't happen, we assist them in returning to work with a different employer," Greene explains.

When an employee simply can't go back to his or her old job, the counselors look for transferable skills. For instance, if someone did volunteer work that involved data entry, they might suggest a data entry job.

Services could include resume preparation, help with improving interview skills, help with filling out applications, and career counseling to help guide the client to an appropriate goal.

"We also look at the possibility of short-term or long-term training," Green says.

Patients are not referred for vocational rehab counseling until they have recovered to the point that they have some functional ability to work.

When members need extra services and hands-on rehabilitation help, the CIGNA vocational rehabilitation counselors call in rehabilitation specialists at Intracorp, a CIGNA subsidiary.

"If we need someone to be face to face and hands-on, we call on the Intracorp staff. They can go on site and look at the job or accompany the client to the job to help alleviate their fears and make the transition back to work," Greene says.

As an Intracorp on-site vocational case manager, **Cherilyn Montgomery**, CCM, CRC, typically meets with the client in person and conducts an initial vocational assessment, looking at his or her abilities and goals and any challenges.

She does role-playing to help the client develop interview skills and develop a resume.

"When I am working with an individual, I consider myself a coach. The client does the hard part. They have to go out and do the interviewing and leg work. I make myself available in case they have any concerns or problems," Montgomery says.

If clients can't go back to their old job, Montgomery conducts a transferable skill analysis to determine what other skills they have, helps them choose areas they are interested in, and does a labor market survey to see what skills are needed in their area.

"I give each client a concentrated effort, working with them on an individual basis. The ultimate goal is to get them back to work in a position that is satisfactory to them and within their interests," she says.

If members decline to participate in the vocational rehabilitation services, the counselors suggest counseling services.

"They may not be at the point that they are ready to do something. Vocational evaluation is part of determining if they are motivated. All we can do is offer the services and make them available," Montgomery says.

As a safeguard against people being reluctant to go back to work for fear that they will fail and lose their benefits, CIGNA's long-term disability contract allows people to try to go back to work without losing their benefits.

"If there is a medical need to go back part time and increase their hours gradually, depending on the contract purchased by the employer, their earnings are offset without necessarily being off claim," Greene says.

In these cases, the vocational rehabilitation counselors put together a rehabilitation plan, making it clear to the client that their claim remains open.

"We convey to the claimant that they can go out and work and don't have to be afraid they can't handle it. If they have to leave the job for medical reasons, it doesn't jeopardize their claim," Antonucci adds.

"It is very important to make the clients aware of the vocational services from the outset. They may not be immediately interested, but we make sure they know that vocational rehabilitation services are available to them in the future," she says. ■

COMING IN FUTURE MONTHS

- How to improve your relationship with physicians
- Program identifies members at risk for suicide
- Coordinating care through the continuum
- Better management of high-risk, high-cost patients

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. ■

CE questions

26. Harvard-Pilgrim estimates that its Health Advance care management program will achieve a ___ reduction in cost per-member, per-month.
A. 10%
B. 20%-25%
C. 5%
D. 30%

27. Horizon-Mercy's social workers who handle publicly insured members with psychosocial needs have an active caseload of ____ cases at a time.
A. 80-100
B. 50-60
C. 150 or more
D. 25-30

28. Last year, 77.72% of members ages 5-56 in Care Choices HMO's asthma management program were prescribed appropriate medications, compared to the national average of 67.93%.
A. True
B. False

29. The disease management component of Independence Blue Cross provides support for members with what five conditions?
A. Cancer, coronary artery disease, diabetes, asthma, depression
B. Asthma, chronic obstructive pulmonary disease, diabetes, heart disease, AIDS
C. Asthma, cancer, congestive heart failure, diabetes, coronary artery disease
D. Asthma, chronic obstructive pulmonary disease, coronary artery disease, congestive heart failure, diabetes

30. The vocational rehabilitation team at CIGNA Group Insurance includes:
A. Telephonic vocational rehabilitation counselors
B. Nurse case managers and claims case managers
C. On-site job coaches
D. All of the above

Answers: 26. B; 27. A; 28.A; 29. D; 30. D.

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