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IN THIS ISSUE

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Member-driven case management/ disease management system pays off

Plan takes a proactive approach to members' health

When Blue Cross Blue Shield of Michigan created its proactive case management and disease management program, the Detroit-based insurer looked for every opportunity to interact with members, in addition to maximizing the traditional disease management and case management strategies.

BlueHealthConnection, a new program launched in May 2002, integrates case management, disease management, and the health plan's 24-hour nurse line, and provides a seamless system for members.

"We call it a program without walls. It's fully integrated, and the patients may move back and forth seamlessly through the levels," says **Jann Caison-Sorey**, MD, MHCA, FAAP, medical director for the program.

Like many insurers, Blue Cross Blue Shield of Michigan found that 10% of its members utilized the majority of case management time and accounted for the majority of benefits usages, he says.

The plan set out to create a program that would provide coordinated care to all members as well as identifying members who ordinarily might fall through the cracks.

The BlueHealthConnection integrated case and disease management program concentrates on four conditions:

1. diabetes;
2. ischemic heart disease (encompassing all diseases that involve narrowing or injury to the vascular system involving heart disease);
3. congestive heart failure;
4. asthma.

The plan is adding cancer management and depression screening this year.

"The four conditions alone account for a significant amount of cost among any population. Many of them are poorly controlled. If the members are not getting the right care interventions, the likelihood is they are not going to have an optimal outcome," Caison-Sorey adds.

Before the program was redesigned, the case management department was reactive, coordinating with the pre-certification staff, intervening when patients had long lengths of stay in the hospital, handling discharge planning, and working with the benefits department to get patients who needed it to alternative levels of care, adds **Michelle Fullerton**, RN, CCM, manager of integrated case and disease management.

"We found that we helped a lot of people but still were very reactive," she says.

Once the patient got home, the case managers backed out of the case and responded only if the patient called them.

"We were letting go of patients who were complex diabetics or had congestive heart failure and who could benefit from additional interventions. We felt we needed to take a more proactive approach instead of being reactive," Fullerton says.

The health plan has had disease management programs since it launched a pilot program in 1994. "Our traditional disease management criteria were very selective. They chose the highest-risk patients. Ours had a very good success rate, but we felt there were other missed opportunities in our overall population," says **Jeff Powell**, MS, MA, manager of outcomes measures and evaluation.

The new program targets members earlier in the disease state process and uses proactive interventions rather than taking the traditional case management approach.

The innovative components include:

- When members call the BlueHealthConnection nurse line for any reason, the nurse who takes the call fishes for any health problems or questions the members or their family may have and gives advice and information on the spot, as well as referring those who may need follow-up to the case management/disease management department.

The nurse line staff are trained in fishing techniques to identify any other health care needs, problems, or concerns that members or their family may have. "We are trying not to miss any opportunity to educate and care for our members," Fullerton says.

For instance, a member may call in to ask when a child needs an immunization. The nurse may talk to him about his own health and find out that the member recently has been diagnosed with diabetes. When the nurse finds out the member has diabetes, she does a diabetic assessment and enrolls the member in the diabetes program. The case managers follow up with a phone call and continue diabetes disease management interventions.

Another example: A member calls in asking about coronary artery disease. When he talks to the nurse, he mentions that his wife had been diagnosed with cancer and was not coping well. The nurse notifies a case manager who calls the couple to discuss the cancer.

"We have four diseases that we focus on, but we are open to handling anything that we find out the member needs," Fullerton says.

- Members who are identified by predictive modeling as being at risk receive a letter from the health plan, explaining the program, then a follow-up telephone call from a case manager. When Blue Cross Blue Shield of Michigan

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Editorial Questions

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started the BlueHealthConnection program, the case managers cold-called any member who met the criteria for the program. Now, they send out an introductory letter before the case manager calls.

"We didn't find cold-calling very successful. The members wondered why their insurance company was calling. Now they are less suspicious and much more appreciative that a nurse is calling to work with them," Fullerton says.

"Having a health insurer doing something for them other than paying claims was not in the realm of their expectations," Powell says.

- When a member is hospitalized for any reason, if he or she has been identified by predictive modeling, the case manager follows up the hospitalization with a telephone call.

"After we fixed the cold-call scenario, we found that if we linked our call with a recent inpatient hospitalization, the member would be even more interested in working with us," says Fullerton.

The plan found that regardless of the reason for hospitalization, the experience left the members more interested in learning about and improving their health.

The case managers call any member who has been hospitalized, even if it's not for his or her chronic condition and even if the gap score and risk scores might not typically warrant a telephone call. For instance, if a member who is at risk for diabetes is hospitalized for a hysterectomy, she gets a call from the case manager, who talks with her about getting her diabetes under control.

"We know that when members have had a brush with the hospital, they feel more mortal at that point. Even though they may have had a diagnosis and know the consequences for a long time, people become more serious about their health following hospitalizations," Fullerton says.

Tying the interventions to recent discharges from the hospital has proved to be an excellent way to get members to participate in the program, she says.

The program has a high success rate. More than 80% of members targeted engage with the plan for some condition. After the plan started sending out the letter, there was a dramatic increase in the number of members who were willing to participate, Powell says.

Member satisfaction has improved. In the plan's annual satisfaction survey, 85% to 90% of members expressed satisfaction with the program, 22% of members who talked to a nurse reported adopting a lifestyle change as a result of the intervention, and 67% indicated that their relationship with their provider improved as a result of interaction with a BlueHealthConnection nurse.

Although it's too soon for any definitive data on return on investment, the health plan's preliminary analysis indicates that the program is highly successful, Powell says.

The statistics on members' compliance with hemoglobin A_{1C} and lipid testing guidelines has improved. ■

Seamless program handles all levels of patient care

CM, DM, and guided self-management merged

Before Blue Cross Blue Shield of Michigan launched its BlueHealthConnection program, disease management nurses and case management nurses were in separate departments and never talked.

Now, the Detroit-based health plan takes a multipronged approach to patient care and, depending on patients' needs and conditions, the same nurse that enrolls them into the program may help them manage their condition and coordinate their care in the hospital.

Case management now is integrated into a broader program that includes disease management and guided self management, says **Jeff Powell**, MS, MA, manager of outcomes measures and evaluation.

The disease manager/case manager may follow the patient through the hospital and back home, acting as a case manager, then start the disease management process again.

The disease management program is structured with interventions designed for members at all stages of chronicity or comorbidity.

"We wanted to broaden the pool of members in our disease management program and used predictive modeling to do that," Powell says. **(For details on the predictive modeling process, see related article, p. 17.)**

Members who are identified through predictive modeling may receive literature in the mail or may receive a telephone call, depending on their gap and risk scores. All members who have been stratified as mid- or high level receive materials in the

mail, followed up by a telephone call.

For instance, all diabetics get a postcard reminding them that the standards of care say they should get a hemoglobin A_{1C} test. The reminder includes the number for the BlueHealthConnection line, staffed by nurses 24 hours a day.

"We've seen good success with our campaign to get our members to comply with nationally accepted guidelines," Powell says.

Guided self-management aids members

Members with lower priority scores who have been identified with a chronic disease but have a low risk of an acute episode are eligible for the plan's guided self-management program.

Guided self-management includes members who are identified when they call into the 24-hour nurse line. If a member or someone in the household is identified with a chronic disease, the nurse asks if he or she is willing to participate in a program.

"We take the opportunity when it comes. We send them literature we have carefully selected to hit on every risk factor and give them an opportunity to educate themselves," says **Jann Caison-Sorey**, MD, MHCA, FAAP, medical director for the BlueHealthConnection program.

Newly diagnosed diabetics receive information on eye exams, weight control and exercise issues, and blood pressure control.

"We may give members with certain conditions an introductory call telling them they are eligible for the BlueHealthConnection program and telling them they can call about any chronic condition 24 hours a day," Powell says.

In those cases, the nurse case managers discuss the modifiable risk factors with members and tell them that if they follow them, they will have better outcomes. They encourage good compliance with medication and frequent visits to the physician.

The case managers establish a rapport with the members and guide them through the assessment process to identify their issues. For example, a member may not have had a hemoglobin A_{1C} test or has been to the emergency department 12 times in a six-month period.

"We assess what the members' issues are and by doing that try to educate them about their condition and what they need to do to keep it under control," says **Michelle Fullerton**, RN, CCM, manager of integrated case and disease management.

The case managers call these members at regular intervals throughout the year, depending on the severity of their condition and their needs. If a patient's condition is extremely acute, the case manager may call as often as once a day.

"It's very member-driven. If a case manager calls a congestive heart failure patient who is gasping, she'll call the doctor's office with the member. We get that involved," she adds.

When the case managers telephone the members, they find that many of them don't fully understand their conditions or the long-term consequences of not managing them early on. "They often don't understand that they need to manage their diabetes aggressively so they don't go blind from diabetic retinopathy or lose their toes," she adds.

The case managers are careful not to interfere with the patient-physician relationship, Fullerton says. Instead, they try to make people responsible for their own health care and to be proactive about taking care of themselves.

"Instead of being directed by a nurse or a physician, we encourage them to take ownership of their own health. Even though we give the information to the members, once they leave the doctor's office, it's up to them. The patients have to be their own advocates," she says.

The nurse case managers provide members with the education they may or may not receive when they go to the physician's office.

The physician may tell a member he has congestive heart failure and explain it, but the member may not have a full understanding of the condition when he leaves the office. "Our goal is to educate the members about their conditions, how they should management them, and what tests they should have," Fullerton says.

Members with diabetes should know that they need a hemoglobin A_{1C} test every three months and remind the physician if he or she doesn't order it. "We are really trying to prompt our enrollees to be aware of the standards of care," Fullerton says.

The health plan considered leaving the educational aspect to the primary care physicians but decided instead to supplement whatever education the members receive at the physician office, Caison-Sorey says. "It's not to say that the physicians don't do what they should do, but they may talk in a way the patient doesn't understand. They may think they have communicated with the member, but when the member leaves, he or she is confused," she adds.

The case management department came up with a patient-driven program.

"When we create plans of care and identify issues, it is with the member and not the hospital discharge planners. We work with the members to determine what they want to do with their health care," Fullerton says.

The disease management component also is member-driven. When they deal with members who have chronic illnesses, the case managers address the members' issues as well as the issues they, as health care professionals, feel are important.

As an example, a case manager was working with a diabetic who mentioned that he had a sore on his foot. The case manager was gearing up to deal with the foot, but the member was more concerned about his diet. She addressed the diet issues with the member while educating him on the importance of foot exams and care.

"We can't take what is important to the patient out of the picture," Fullerton says. If a member who is in the program is hospitalized, his or her midlevel disease management/case management nurse knows immediately, thanks to a new integrated computer system. In the past, the disease management case managers didn't find out about inpatient hospitalizations until much later.

The case managers have access to information about the member through pharmacy records, claims data, and inpatient and outpatient utilization. When they study the data, the case managers are able to see how the members' health care is being addressed.

One case manager identified a patient who was seeing 12 specialists with no listed primary care physician coordinating the care. "It's very fruitful for the case managers to see the practice patterns. It helps us to discuss the conditions with the members and better coordinate their care," Fullerton says. ■

Predictive modeling used for CM/DM interventions

Risk scores, gap scores indicate interventions

When Blue Cross Blue Shield of Michigan decided to create a proactive case management and disease management program, the Detroit-based insurer turned to predictive modeling to identify which of its members were eligible for the BlueHealthConnection program.

"We have a huge population. We are using predictive modeling because we don't have the resources to have an impact on every member in the depth that we would like. We have developed a strategy to at least touch every member," says **Jeff Powell**, MS, MA, manager of outcomes measures and evaluation.

Almost 5 million members are covered by Blue Cross Blue Shield of Michigan, and 1.9 million of those are covered under BlueHealthConnection.

The insurer provides claims data and other information to an outside vendor specializing in predictive modeling to identify members who are eligible for the program.

Targeting three disease groups

The company has identified 68,000 diabetics, 3,500 members with congestive heart failure, 32,000 with ischemic heart disease, and 72,000 with asthma.

In creating its proactive case management model, the health plan started with diabetes and researched evidence-based literature to find the essential interventions that should occur with each of the populations and modifiable risk factors for each condition.

For instance, members with ischemic heart disease should manage their lipid protein levels and diabetics should monitor their hemoglobin A_{1C} levels every three months and have regular eye and foot exams.

In establishing the model, the health plan considered the population's age, gender, utilization patterns, comorbidities, and gaps in care, which include how often they see a physician and how often they have a recommended test or procedure.

The predictive modeling process stratifies the population and assigns a risk score and a gap score, showing if there is a gap in care.

The plan has established a numerical cutoff with risk scores and gap scores. Anyone who is above a certain point is considered high level or midlevel and is targeted for outbound calls from the case managers.

"We try to engage them and get them involved in a program," adds **Michelle Fullerton**, RN, CCM, manager of integrated case and disease management.

If a diabetic hasn't recently had a hemoglobin A_{1C} test, the case managers try to fill that gap by educating the member about the importance of the test so he or she can discuss it with the physician.

"The data we feed into the process set priorities in risk and gap scores. As we get more experience,

we keep refining the predictive modeling. We want to get the right people at the right time with the right message," Powell says.

In addition, the insurer has developed its own predictive modeling for specific conditions, such as cancer. The company looked at several years of historical claims data and looked at variables to identify the likelihood of a member continuing along the cancer care continuum.

The health plan's own predictive model is based on research that shows that certain conditions have a high association with comorbidities. Among them are back pain, benign prostate hypotrophy, and benign uterine conditions. The risk score includes many different criteria. It takes into account if a member has seen a physician for low back pain and has had recent imaging procedures.

"When we look at these, we may identify someone who has back pain and is trying to make a decision as to whether to have surgery," says **Jann Caison-Sorey**, MD, MHCA, FAAP, medical director for the program.

In this case, the company sends out a video that educates the member about the latest surgical techniques, contains testimonials from patients who did and who did not have the surgery, and includes other treatment options.

"The video doesn't drive the member to one decision or another, but when they view it, they come away with an in-depth knowledge of their condition and the pros and cons of their options," Caison-Sorey adds.

Screening for depression an important key

The health plan has begun using a new screening tool for depression.

"When we looked at our population profiles, we noted an undercurrent of depression. Depression is one of those issues that often goes unaddressed, but it keeps patients from doing things to help themselves," she says.

Patients with congestive heart failure should be taking three medications a day, but if they're depressed, they could miss a dose or fail to take their medication at all and end up in the hospital.

The case managers use the screening tool for members who have chronic conditions to identify people who may be depressed. If the screening shows possible depressions, the case managers tell the members that their answers to the questions indicate that they may need to discuss depression with their primary care physician. ■

Regional offices bring CMs closer to clients

Care is targeted to regions' specific needs

It's not unusual for members covered by Blue Cross Blue Shield of Arkansas to drop by the office and visit their case manager in person.

"Many times, we have members who are coming into the city for a doctor visit and they stop by the office and visit their case manager," says **Niki Wilson**, RN, CCM, HIA, manager of enterprise medical management for Arkansas Blue Cross Blue Shield and its affiliates.

This close relationship between case managers and clients has occurred since the Little Rock-based insurer set up seven regional offices, located throughout Arkansas.

Each office is full service, with marketing and customer service, a medical management team that includes a full- or part-time medical director, a full-time or part-time medical affairs manager, and one to eight RN and CCM-certified case managers, depending on the size of the region.

The insurer moved to comprehensive regional offices in 1995 and decentralized case management when the regional offices opened.

Prior to that time, the company had small offices located throughout Arkansas with staff who primarily worked in marketing. Case managers worked out of Little Rock and traveled to the regions they were assigned to handle.

"We regionalized so we could get closer to the customer. Even though we are a very small state, the regions have very different markets," Wilson says.

Members may call the customer service office in their region, or they can walk into the office to talk to a customer service representative. "The people who work in the regional offices have lived and worked in the area. They are familiar with the physicians and hospitals and have developed a working relationship with them," she says.

Working in regional offices gives the case managers an opportunity to build collaborative relationships with the physician community. Many of them have worked in local hospitals before joining Blue Cross and already have relationships with local physicians and the facilities, Wilson says.

"Those who live in the area have an instant rapport with the hospitals and physicians," she says.

They have the additional advantage of being familiar with the employer groups in their area.

"The fact that they are familiar with everyone in their community is one of the reasons we put the case managers in the region," Wilson says.

The case managers do on-site as well as telephone case management, working closely with the local providers. The case managers use their clinical judgment and experience with the health care team and home care vendors to determine when an on-site hospital or home visit is appropriate. A home or hospital visit is strongly encouraged if the case is open 30 days or longer and is required for particular types of cases, such as patients who are ventilator-dependent, who have been catastrophically injured, or who are potentially noncompliant.

The insurer did away with precertification two years ago. "When we did that, we had a relationship built with the hospitals and, as a trade-off, they agreed to give us the hospital census so we could determine which patients were appropriate for case management," Wilson says.

The case managers work closely with the hospital to review the census of members covered by the different product lines and get their primary referrals from the hospital.

When patients are in case management for a long time, the case managers do home visits, working closely with the home health agency and other home care providers.

They identify the benefits and coordinate care, working within the benefits to make sure they maximize the care the patients can get with their benefits package.

The case managers also handle case management outside of Arkansas for large national accounts.

"Our case managers have the advantage of working with case managers in other Blue Cross plans to coordinate care for members who are not in Arkansas," Wilson says.

If a case manager needs to find a home infusion therapy company in another state, he or she contacts the local Blue Cross plan to find out with whom they contract. If the plan doesn't have a contract with a company, the Arkansas case manager negotiates the rate.

The insurer has always had a vendor to do precertification so the company's case managers won't be the ones approving or denying care.

"We wanted specifically to keep the utilization review and case management roles separate," she says.

The case managers still work on educating the physicians in their region about their role and what they can do to make the physicians' lives easier.

"The more we get into disease management, wellness, and prevention, the more collaborative relationships we are going to be able to develop with physicians," Wilson says.

Little turnover in CM program

The case management program has little turnover. About 75% of the case managers who worked for the company when the regional offices were established are still there. A few have retired. Others have moved out of state.

Employer groups may have a corporate office in one region and employees living in other regions. The case managers work closely to make sure the care is consistent.

"They all know each other and work closely together. Our case management system is set up so that if one case manager wants another to consult on a case, they can have access to each other's files," Wilson says. "They all know each other and always feel very comfortable in calling each other," she explains.

Four offices have full-time medical directors. The medical directors are responsible for clinical oversight and are available to the case managers if they have any problems with cases. For instance, the case managers may call on them for help with difficult decisions or to intervene if they think that a local physician would respond better to another physician.

Each regional office has developed a regional medical management committee made up of local physicians in active practice who work closely with the Blue Cross medical directors and have input into coverage policy.

"We really do try to include the provider community in all medical management. It's easy to do because we are decentralized and the local physicians have better rapport with the local offices," Wilson says.

The marketing team in the regional offices often calls on the case managers to talk to an employee group about the medical management program.

"I feel confident in saying that the case managers have sold many groups," she says. ■

Regional offices have autonomy, consistency

Policies and procedures are the same

The regional offices of Blue Cross Blue Shield of Arkansas each have their own identity but they follow consistent policies and procedures based on URAC standards for the company's case management program.

Establishing consistent policies for case managers to follow is an important part of decentralizing your case management activities, says **Niki Wilson**, RN, CCM, HIA, manager of enterprise medical management for Blue Cross Blue Shield of Arkansas and its affiliates.

Consistent policies and procedures among the regions are essential in determining outcomes on a companywide basis, she says.

It's difficult to do any meaningful reporting on a companywide basis when each region tabulates its cost savings a little differently, Wilson points out.

She has the responsibility of supporting the medical management programs, the medical management teams in all regions, is a facilitator for the medical management council (the quality improvement committee with oversight for case managers), handles special projects, and is the liaison with the utilization review company.

The case management program has earned URAC accreditation, from the Washington, DC-based organization, a process that Wilson calls "the best thing we ever did" because it provided consistency throughout the region for documentation of case management outcomes and calculating savings from case management interventions.

The URAC accreditation came about as a result of the case management relationship with the Federal Employee Program, which applied for URAC accreditation.

The insurer was required to become compliant with the standards but wasn't required to become URAC-accredited.

"We took it a step further and went through accreditation for all our lines of business," she says.

The regions have a lot of autonomy by necessity because there is a different customers base in each region and different community needs and services.

For instance, the northeast region has taken an active role in community wellness programs, and the staff work closely with employer groups to set up health fairs and other projects that promote wellness.

In the central region, the case managers work closely with the employer groups.

When they begin working with a new employer group, the case managers do a focused report, determining the top 10 problems that particular group may have.

For instance, some populations have a lot of diabetes or coronary artery disease. In those cases, the case managers work with the group to try to get members enrolled in an appropriate disease management program. They work with them on health fairs and make "lunch-and-learn" presentations for the employees.

Quarterly meetings

All of the regional case managers know each other and frequently call each other and collaborate on care.

They get together for quarterly meetings coordinated by Wilson. Each meeting includes educational presentations for which the case managers can earn the CE credits necessary to maintain their certified case manager (CCM) certification.

The case managers are required to get and maintain their CCM certification. If they aren't certified when they are hired, they are required to become eligible to sit for the examination with two years. The company pays for the certification process and reimburses case managers for continuing education. CCM certification requires 80 hours of CE over a five-year period to maintain it.

The quarterly meetings include continuing education, time for the case managers to share programs they have developed in their own communities, and opportunities for the case managers to visit with their fellow case managers.

"The quarterly meetings also are our opportunity to keep the case managers up to date about any changes going on in the company," Wilson says.

The company's case managers work with all different lines of the company's business, including the HMO, PPO, indemnity, and TPA for the self-insured.

"It's a real challenge for anyone coming in new to learn insurance and the different lines of business. Each line of business has different benefits for the case manager to handle," Wilson says. ■

NICU case management pays off for health plan

Program cuts average of four days off length of stay

A case management program dedicated to infants in the neonatal intensive care unit (NICU) has saved Blue Shield of California an average of four days length of stay off each NICU admission, saving the health plan about $3,500 a day.

"We have been very successful with this program. Our success is due to a combination of things from my perspective," says **Kathy Hoksbergen**, RN, MHA, director of medical management operations. "We promote early parent education so parents will feel comfortable taking their baby home from the hospital. If we don't start educating parents until the doctor says the baby is ready to go home, the discharge will be delayed."

The health plan, based in San Francisco, started its neonatal case management program two years ago when it discovered that monthly case reports consistently showed that about half of the plan's catastrophic patients were premature infants.

At the time, the health plan had a case manager with a specialty in neonatal intensive care management but not a neonatologist on the staff and contracted with a vendor specializing in NICU case management, Hoksbergen says.

The plan initially assigned a nurse with an NICU background to work as a liaison with the vendor.

Cost-effective management

Within about a year, the staff at Blue Shield of California determined that having a vendor manage the infants was not the most cost effective way to manage the infants' care.

"We determined that we could perform the same functions as the vendor and do them more efficiently and cost effectively," Hoksbergen says.

In the beginning, the plan referred all infants who weighed less than 1,500 g to the vendor and managed the others internally by telephone. Eventually, the Blue Shield case management department handled the care of all of the low birth weight and premature infants.

"Working with the vendor, we were able to build our knowledge and resources internally. We can get just as good results without the cost of the vendor when we handle the cases ourselves," Hoksbergen adds.

Now the program has a dedicated case manager who specializes in handling infants in the neonatal intensive care unit and a board-certified neonatologist. She is supported by two other nurse case managers with experience in handling babies in the NICU, adds **Paula Ackerman**, RN, BSN, CCM, supervisor of case management.

Blue Shield of California is notified by the area hospitals when there is an NICU admission. The neonatal care manager assesses all infants, making an estimated length of stay based on the gestational age at birth or the mother's estimated date of delivery.

If the baby meets the criteria for NICU case management, a Blue Shield case manager handles the care.

Whenever possible, the health plan facilitates the infant's admission to a tertiary center adept at handling premature infants.

"We try to get the baby channeled to a facility that can specialize in its needs. Our case manager works closely with utilization review and discharge planning departments at the facility and works to line up community services when they are needed," Ackerman says.

Discharge planning

The goal of the program is to start discharge planning early and to educate the parents as soon as possible so they'll be prepared to take the infant home as soon as it is appropriate, Hoksbergen says.

Typically, active discharge planning begins when the baby reaches a corrected gestational age of 34 weeks. The corrected gestational age of the baby is based on a 40-week gestational period during pregnancy. A baby born early at 30 weeks gestational age would have a corrected gestational age of 34 weeks four weeks later.

The case manager works with the physicians, parents, home health, and durable medical equipment providers to develop a working care plan to address the infant's needs and follows up regularly during the hospital stay by making biweekly utilization reviews and following up with the parents and home care providers after discharge.

"Some babies require very complex care after discharge. In those cases, the NICU case manager works with the parents and the provider to create an appropriate care plan," Ackerman says.

(Continued on page 23)

Case Study of an Infant Needing Complex Care

On July 5, 2002, Baby A was born at a term gestation of 38 week by emergency cesarean due to prolonged decelerations. The infant had Apgar scores of 0/0/0 at 1/5/10 minutes, respectively, and a poor score of 4, 20 minutes after birth.

A grim prognosis was given to parents. The baby was put on the ventilator and anti-seizure medication. No gag/suck reflex was initially noted. Diffuse cerebral edema was noted. The baby was having multiple seizures and was on IV Dilantin, Ativan, Phenobarbital.

The Blue Shield of California NICU care manager followed the baby's course throughout the hospitalization. The case was formally opened to case management in August after the baby was stable and discharge home was anticipated. The case management through June 27, 2003, as coverage with Blue Shield of California terminated effective July 1. However, the mother continued to communicate with the case manager and provide updates on the baby's progress through October 2003.

Here are the case manager's progress notes:

- **07/12/02 -** Extubated to nasal continuous positive airway pressure.
- **07/13/02 -** Weaned to Oxyhood.
- **07/14/02 -** Weaned to room air.
- **07/22/02 -** EEG noted some improvement. Gavage feeds.
- **07/25/02 -** Continues to demonstrate lack of gag reflex.
- **08/01/02 -** Attempting to nipple-feed but weak suck/gag.
- **08/06/02 -** Trying to consolidate feeds, currently 8 cc over 1 hr. Parents need to be instructed on maintenance/insertion of nasogastric tube before safe discharge. Parents refuse G-tube insertion, and believe that the baby's outlook is not all gloom and doom that MDs have told them.
- **08/08/02 -** Converted to bolus feedings every 3 hr.
- **08/11/02 -** Parent teaching complete. Baby discharged home. Parents are very comfortable with gavage feeds. Home Health Care is arranged through Pediatric Services of America.
- **08/16/02 -** Called Mom to discuss case management services. Received permission. Reviewed available benefits/ current resources and discussed obtaining authorizing social worker to assist parents with locating local/community/state/federal resources that baby may qualify for to reduce out-of-pocket expenses for family. Mother states she is unable to work since child is full-time care and sole income is through spouse and that she welcomes any help with finances. The parents agree to care plan. Will follow up for Early Child Intervention/Easter Seals for therapies. The mother is encouraged to look up information on nationally recognized Internet sites to obtain more information regarding daughter's diagnosis. The mother was encouraged to create a folder with sections and tabs to separate all specialists appointments/claims and explanation of benefits as well as a list of contact numbers for doctors, insurance contacts, home health care, and durable medical equipment providers and community resources. Mother very responsive.
- **08/30/02 -** Baby noted to have increased tone and neurological involvement. Collaborating between home health agency/attending physician's office and social worker to ensure that referrals in place and follow-up appointments for evaluation of program eligibility is completed.
- **11/2002 -** Assisted family with obtaining name of pediatric neurologist within 60 miles of family's home since attending physician was terminating his contract with Blue Shield of California. Advised about continuity of care request for baby. Blue Shield approved services rendered by current neurologist under continuity of care. The physician subsequently renewed his contract with the local blues plan. Therefore, there was no break in the baby's care. Baby making progress with some developmental milestones, starting to smile. Parents very encouraged. Mother thanking case manager for listening to her insecurities and giving her someone to talk to who understands what they are going through, since outwardly, baby does not appear unusual. Mother looking up information on Internet and seems encouraged.
- **01/10/03 -** Unable to obtain follow up with parents, left message about closing of case as goals had been met. Mom called back requesting continued case management because she feels it has helped her to cope much better with baby and 3-year-old son.
- **02/03/03 -** Baby making progress in motor skills. Moving legs in meaningful ways, smiles. Acknowledging caregivers. Mother wants to meet case manager on next trip to California to show her the baby's progress. Baby has made progress with fine motor skills.
- **04/09/03 -** Baby is making progress with taking food off a spoon. Communicating with sounds. Starting to have increased balance.
- **05/14/03 -** Surgery for placement of G-tube and fundoplication since still not taking enough nutrition by mouth. Diagnosed with cerebral palsy.
- **06/04/03 -** Mother thanked case manager again for helping her to gain confidence in her ability to collaborate with treatment team and in her ability to care for baby. Reported that husband had lost his job (subscriber) and family cannot afford COBRA payments. Discussed requesting social worker prior to cancellation of policy to assist with paperwork in obtaining Medicaid. Mother had already contacted a caseworker for Medicaid and made a financial eligibility appointment. She has felt more empowered from interaction with Blue Shield of California case manager. The file book she established at the case manager's suggestion has allowed her to keep track of all important disciplines for baby. She feels more confident in interaction with doctors. Baby is working with nutritionist as well, provided by Easter Seals.
- **6/27/03 -** Case closed as parents have demonstrated ability to independently address the baby's needs with the care team and various resources.
- **07/01/03 -** Coverage canceled.

(Continued on next page)

- **07/29/03 -** Call from mother reporting that the family has been approved for Medicaid; baby is making more progress with eating from spoon, smiles on demand. Improving motor skills. Husband still out of work, but she is feeling better about herself and may return to job force and teach spouse to care for baby full time. Thanked case manager for involvement.
- **10/23/03 -** Received call and e-mail from mother with new pictures of baby. Mother thanked case manager for having confidence in her. She feels good about her ability to be assertive for benefit of daughter and will start working soon.

Source of charts on page 21 and above: A Blue Shield of California care manager with eight years' clinical NICU experience.

For instance, if the baby will need home health, the case manager facilitates finding a home care agency that can handle the infant's special needs and makes sure a referral is in place on the day of discharge.

One of the biggest difficulties is finding a home care agency that specializes in the care of infants with complex needs, Ackerman points out.

The care manager works with the family to identify preferred home health and durable medical equipment providers in the family's area who can take care of the baby's needs.

If the family lives in a rural area, it's extremely important for the parents to be trained in CPR, use of feeding tubes, and whatever else it will take to care for the infant, Ackerman says. Due to limited resources in their community, the parents need to be able to rely on their ability to care for the infant until more highly trained support is available, she adds.

The care manager follows up with the facility's social worker and discharge planner to make sure the baby is referred to community and state resources such as public health nursing or California Children's Services if appropriate, based on the infant's diagnosis, developmental disabilities, and financial need.

The plan has on-site patient care coordinators who work in high-cost, high-volume facilities throughout the state. The on-site case managers handle all catastrophic patients who are in the acute level of care. They coordinate with the neonatal specialist on the care of infants in the NICU.

The on-site case manager is primarily responsible for on-site review and gets the NICU case manager the information needed for discharge planning.

"The on-site nurse is focused on the hospital stay. The NICU case manager is focused on the entire continuum of care," Ackerman says.

The NICU case manager communicates with the family while the infant is in the hospital and after discharge.

COMING IN FUTURE MONTHS

- Why you must get on the technology bandwagon
- How to calculate the value of case management
- Ways to improve relationships with providers
- Award-winning disease management programs

CE questions

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.

6. The Blue Cross Blue Shield of Michigan's Blue Connections program concentrates on what four conditions?
   A. CHF, diabetes, cancer, and COPD
   B. Ischemic heart disease, diabetes, CHF and asthma
   C. Depression, coronary artery disease, diabetes, CHF
   D. Coronary artery disease, diabetes, asthma, cancer

7. How many members of Blue Cross Blue Shield of Michigan have been identified as having diabetes?
   A. 68,000
   B. 40,000
   C. 25,000
   D. 80,000

8. Arkansas Blue Cross Blue Shield moved to regional offices and decentralized case management services in what year?
   A. 1990
   B. 2001
   C. 1992
   D. 1995

9. When Niki Wilson of Arkansas Blue Cross Blue Shield talks about "the best thing we ever did" she's referring to URAC accreditation.
   A. True
   B. False

10. Blue Shield of California's neonatal case management program cuts how many days off the average hospital stay for infants?
   A. 2
   B. 4
   C. 1
   D. 6

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

The care manager works with preferred home health agencies to follow up in the home for continued patient education and home safety evaluation. In cases where a contracted home health agency is not located, the care manager has the ability to negotiate with a noncontracted home health agency able to provide the care.

The case is open for case management until the infant's goals have been met. In some cases, the NICU case manager still is working with the infant's parents a year after discharge. In other cases, she may close the file after 90 days. The time a baby remains in case management depends on the severity of illness and the amount of care that is required to complete the goals set between the care manager, parents, and care team.

"The case manager helps familiarize the family with community resources that can provide services which may not be covered by the plan or in the event a particular plan benefit is exhausted," Ackerman says. ■