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Medical directors are a great source of support for case management

Teamwork helped to optimize patient care

If you're not calling on the resources of your company's physician medical directors, you may not be maximizing your resources to optimize patient care.

"Physicians who have oversight of case management programs can play an important role in supporting and directing clinical and resource care coordination," says **Sam D. Toney**, MD, president and founder of Health Integrated Inc., a Tampa, FL-based company that provides integrated case management, utilization management, and disease management services for health plans, physician organizations, government entities, large self-insured employers, and other clients.

At Health Integrated, staff take a collaborative approach to case management with the nurses and physicians working as a team.

"There is a much bigger role in case management for the medical director other than just deciding whether something is an appropriate intervention," says **Cheri Lattimer**, BSN, the company's executive vice president for clinical services.

Case managers should call on their medical directors for help with clinical care coordination, compliance issues, and pharmacy issues as well, she adds.

Health Integrated developed the collaborative care model as the result of interviews with the case managers. "As we talked to case managers about what is really happening as they work with their patients, they told us they need to have care conferences with physicians who can help them identify from the clinical side what might be barriers to the patient not achieving their goals," Lattimer notes.

Here are some of the ways that the Health Integrated medical directors collaborate closely with the case managers:

• **Pharmacy monitoring**. If a case manager feels that a member may be getting the wrong dosage or the wrong medication, he or she can call on the medical director to look at it and contact the attending physician.

• **Dealing with a rare illness**. Medical directors should be called when

a member has an illness that the case manager encounters infrequently and there is not a clinical protocol for managing the care. For instance, Lyme disease is not common in most parts of the country, and the case manager might need the expertise of the medical director to manage the case.

• **Problems with the attending physician**. If the patient's physician hasn't been available when the patient needed refills or when the patient needed an appointment, the case manager should ask the medical director to look into it and determine if the barriers can be overcome or if the patient should be referred to a new physician.

• **Experimental treatments**. If the attending physician suggests a treatment option that is considered to be experimental or investigational, the medical director can review it to see if it's appropriate for the patient.

• **Reviewing troublesome cases**. For instance, if a case manager is working with a member with significant issues who is not moving appropriately through the health care continuum and isn't reaching his or her goals, the physician can help spot obstacles to optimal care.

• **Bridging the gap between the primary care physician and case manager**. Some physicians either don't return calls or don't work collaboratively with case managers. The medical director often can intervene and be the representative for the case manager.

For instance, one case manager brought the case of a member who wasn't taking his medications. The member was on multiple medications, had trouble remembering when to take what pill, and didn't have a medication organizer. The member also told the case manager that sometimes he didn't have the energy to get out of bed to take the medicine.

"This was a red flag that the patient might be depressed. The care manager discussed the problem with the physician, and they worked together to get the member screened and treated for depression," Lattimer says.

The company holds regular and frequent case staffing meetings that include the entire team — physician, nurse case managers in both the medical and the psychiatric components of the company, utilization management nurse, and anyone else involved in the patient care.

"Our goal in every case is to identify the medical as well as the behavioral aspects of each case and determine any other options to manage the patient's care," Toney says.

Case managers at Health Integrated have several ways of reaching the medical directors for help in managing their cases.

They can bring targeted cases to the team case-staffing meeting for discussion or flag a case for review through the company's software platform.

"I have an open-door policy with the nurses and will meet with them in my office if that's the most efficient way to get the job done; but in most cases, the electronic notification is effective," Toney says.

The company also has the ability for the case manager to transfer a patient directly to the medical director in acute cases.

The medical directors and case managers at Health Integrated worked together to develop clinical guidelines and tools that the case managers use every day.

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Editorial Questions

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

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"On the front end, the physician should be part of a development design team that puts into place all of the specific protocols, criteria guidelines, and assessment tools that any good case management organization must have today," Toney says.

The role of medical director is vital in the quality improvement process as well, he asserts. "They should be able to go through the interrater reliability studies and discuss the protocols and criteria used by nurses. The medical director should be available not only at the front end but during the ongoing modification of the protocols."

On a day-to-day basis, case managers should use the physician as a resource to provide individual clinical review of troublesome cases, Toney adds.

At Health Integrated, Toney reviews individual cases with the case management nurse as well as reviewing the protocols the nurse is using to monitor and coordinate the patient care.

"The second level, if appropriate and necessary, is peer-to-peer interaction between the medical director and the attending physician to discuss issues we uncovered clinically, treatment options the physician may not realize are available under the patient's covered benefits, and to look at multiple ways of approaching various disease states," Toney says.

Under his direction, the company's physicians are providing cross-training for the nurses on the medical management side of the company as well as the behavioral management side.

"Every case has both medical and psychological components, and the case manager does not have to be a psychiatric nurse to handle some of the behavioral aspects," Toney says.

The medical nurses are being cross-trained to handle behavioral issues and coordination of resources from the psychiatric side of care while the psychiatric nurses are receiving medical cross-training.

"Not only do the doctors work as a team in coordination of care, they are now working from the coordination of training. It's a wonderful feeling from a nursing perspective because the physicians are getting in the trenches and working with the care managers instead of just having oversight," Lattimer reports.

Establishing the close working relationship between the physicians and case managers has been a challenge for some seasoned case managers whose longtime approach has not included physician interaction, she says.

"Over time, as we built the team approach, these nurses have provided input that they see the physician interaction as a tremendous advantage. Our case managers have told us that the help and support from a strong medical director, as well as using the clinical guidelines we have developed, have built a collaborative practice," Lattimer adds.

Involving the nurse case managers in the design of the company's clinical protocols and care plans helped to build the team at Health Integrated, Toney notes.

As Health Integrated has developed the protocols, the company's principals have made sure that they are user-friendly for case managers and in no way add more time to their day.

The company has been testing a new stratification tool with the case management nurses and getting their input.

"One of the things we heard over and over was that, while they want consistency and guidance, the nurses also want their lives to be made easier, not harder, by the new technology," Lattimer says.

The company takes a two-level approach to care pathways, starting with the global pathway that looks at the psychosocial and continuity-of-care aspects that are a part of every case and a specific care pathway for 45 different disease states.

"We start with the global perspective and a general care plan and come up with a variety of goals and interventions, then drill down to the specific disease state," Lattimer reports.

The integrated process guides nurse case managers who handle the care of members with comorbidities away from opening a specific care path to assessing all aspects of care.

"We look into the reasons the member may not be adhering to the treatment plan. It may be that they don't understand their illnesses or that there are social issues or other barriers to care," says Lattimer.. ■

CMs coordinate care for at-risk members

CM and UM departments are separate

A program in which case managers coordinate the care of members with complex medical conditions and those who are at high risk for

chronic diseases has paid off for Care Choices HMO of Farmington Hills, MI.

Separate departments

Evaluation of the case management program is based on member satisfaction, functional improvement, and resource utilization.

"Our utilization measures such as bed days per thousand, admissions per thousand, and length of stay are at a very good rate. Case management is an integral part of the disease management programs and as such is included in the return-on-investment analyses," reports **Saraja Samuels**, RN manager of medical management.

The health plan made the decision several years ago to have separate departments for utilization management and case management.

"When we started the program, the case managers did utilization review and case management. Now, we have certified case managers who strictly do case management," Samuels says.

When case managers also handled utilization management, that was their priority, and case management was always on the back burner, Samuels says.

"This way, the case managers have no distractions. They can concentrate and spend time on managing the patient care. In the case management area, people are very fulfilled, very happy, and helping the members," she adds.

Care Choices HMO Case Management Program deals with members who are at high risk for chronic diseases; those who have an illness that could lead to a high-risk condition; and members who need increased use of health services.

The Care Choices disease management team handles routine disease management.

If a member with a chronic disease is hospitalized or visits the emergency department, the case managers handle his or her care.

For instance, the disease management team would manage members who have their asthma under control. If they end up in the emergency department, the case manager would take over the care.

"The members whose care we manage are those who are at risk," says **Karen Bray**, RN CCM, team leader for case management department.

The HMO Case Management Program also provides care for patients with increased use of health care services, such as those who are being followed by several specialists, have multiple durable medical equipment needs, or need extensive wound care.

Patients who are waiting for a transplant, those with end-stage renal disease and spinal cord injuries, and premature infants also are referred to case management.

The severity of a member's disease determines whether he or she gets into case management. For instance, when a member is diagnosed with hypertension, the disease managers get the information from pharmacy data and send the member information about blood pressure.

"If a member has high blood pressure and is going to work every day and keeps it under control, they don't need case management. If they're going to the emergency room a couple of times a month or end up in the hospital, it means they're not managing the disease, and that's where case management come in," Samuels says.

The Care Choices HMO case managers work with the member and the primary care physician to assess the member's health care needs and develop a customized plan.

They coordinate services, monitor the member's compliance with the plan, and evaluate treatment plans on an ongoing basis.

The goal is to help the members manage whatever disease or condition they have, Samuels adds. "Some are not going to be 100%; but if they can live with the disease they have, go back to work, and live a normal life, that's our goal," she says.

The staff in the HMO Case Management Program are experienced case managers with medical/surgical backgrounds and different specialties.

"We all work with all members; but if there is a case that comes up that needs someone with a more specialized background, we have case managers who can handle it," Bray says.

For instance, she has experience with transplant patients and handles all of the transplants.

When a patient is referred to case management, the case manager collects patient history, pharmacy data, and other information, then calls the primary care physician to get his or her approval for the patient's enrollment.

If the member has an acute need, the case manager calls him or her. If the need isn't acute, she sends an introductory letter and follows up with a telephone call.

"I have found from my past experience that people are more apt to speak to you if they know you're going to call and know why you're calling," Bray says.

The letter explains the benefits of case management and asks the member to call at his or her convenience. If the members don't call within a couple of weeks, the case managers call them.

An acute patient who would warrant an immediate phone call might be someone referred by utilization review who has new-onset diabetes and has been hospitalized.

"Hospital stays are much shorter these days, and teaching is more intense and quicker," Bray says. "Diabetes is an overwhelming diagnosis, and it's hard for someone to understand quickly what is happening."

With the acute patients, case managers try to call on the day of discharge, making sure the patient has whatever durable medical equipment he or she needs and is clear on when to make a follow-up visit to their physician.

"We let them know the benefits of case management and our educational resources. If they seem to be overloaded, I'll leave a number and ask them to call in a few days," Bray says.

Member education

Patients who receive a letter before a case manager calls are likely to be people with a chronic disease who have been to the emergency department or whose pharmacy data indicated they haven't been complying with their medication.

"We try to find out their knowledge base regarding their condition and go from there. If they seem to be knowledgeable, it might be a compliance problem that means a follow-up with the physician or change in medication," Bray says.

If the members' problem is compliance with their treatment regimen, the case managers educate them and tell them the benefits they have with the health plan, Samuels notes.

"Many people don't know that they can have two nutritional consults a year. Others don't know that diabetics should have specific lab tests or have a dilated retinal eye exam each year. They think that if they go to the physician every year, they're doing everything they should," she adds.

The case managers educate them on what they should do to keep their condition under control and let them know what benefits they have at Care Choices that can help them manage their diseases themselves, such as weight management and smoking cessation programs, Samuels says.

If members' benefits have run out or they have needs that aren't covered by the health plan, the case managers will help them find community resources. For instance, there are community organizations that will provide wheelchair ramps and others that will help pay for medication that isn't covered.

"We perform telephonic case management; but if we feel that a patient needs an assessment of the home environment, we make arrangements for a visiting nurse or home care nurse to do the assessment," Bray says.

The case managers follow the members as long as they need it. Patients whose conditions are fairly stable but still need some oversight are put on monitor status.

For instance, the case managers follow patients with end-stage renal disease and monitor them closely after they start dialysis. If they are stable, they are put on case management monitoring status and are not in active management again until they start having problems or need a kidney transplant.

Transplant patients are handled from the time the health plan gets a request for an evaluation visit until a year or two after the transplant.

"It's really individualized. I had one case that was in case management for two weeks and others who are awaiting a transplant or who have multiple comorbidities that require case management intervention for two years or more," Bray says.

The case managers close the books on members when the members have a good knowledge base about their condition, are stable, are in compliance with their treatment regime, and follow up with their primary care physician at least once a year.

"If we are comfortable and they are comfortable, we close the case," Bray reports.

The case managers are assigned to patients being treated by particular provider panels.

"It's helping; because when we work with the provider offices, the nurses and physicians get to know the case managers," Samuels says.

Each of the four case managers handles between 120 and 200 patients at any given time. Many of them are on monitor status, and the case manager may just touch base every month or two, Bray reports.

Others require more intense interventions. "I have had several members I called daily or every other day for two or three weeks on end. These are patients with multiple comorbidities or those who have had a lengthy inpatient admission. Once they get home, I want to make sure they have everything they need so they don't end up in the hospital," she says. ■

Depression program boosts HEDIS scores

Members stay on their medication longer

A depression management program has resulted in better scores on Health Plan Employer Data Information Set (HEDIS) measures and a reduction in depression screening scores for Fallon Community Health Plan, with headquarters in Worcester, MA.

Over the last three years, the six-month continuation of treatment among Fallon Community Health Plan members has increased from 37% to 59%, placing the health plan above the 90th percentile nationally.

Members who are in the depression program have showed a 76% reduction in scores on the Beck Depression Inventory (BDI), a 21-item questionnaire that gauges how depressed an individual is. The average BDI score has dropped from 15 to 4.

Favorable satisfaction noted

Member satisfaction with the program is high. Members enrolled in the program gave their interactions with the care managers a score of 91%, compared with average scores in the mid-80th percentile among all practitioners in the system.

"We've seen a positive impact in a number of areas. Our HEDIS scores show that we are on the right track," says **Wally Mlynaryk**, MHA, director of disease management for the health plan.

Here are Fallon Community Health Plan's HEDIS scores:

- optimal practitioner follow-up contacts (three visits within 90 days): 45%;
- acute-phase medication treatment (continued at least 90 days): 79%;
- continuation treatment (at least six months of medication): 59%.

Fallon started its depression management program three years ago.

"We saw the opportunity in terms of our HEDIS scores and the fact that our inpatient utilization rate for depression was pretty high," Mlynaryk says.

The plan began by surveying its primary care physicians to find out how they viewed depression management and what kind of clinical support and patient resources they would prefer.

The physicians reported that they were interested in receiving treatment guidelines and diagnostic tools.

A survey of patients who had discontinued their antidepressant medications prematurely showed that the majority stopped taking the medication because they didn't understand the need for prolonged treatment.

"Patients often have difficulty with the medications for depression. If they had a side effect, they would stop taking it because they didn't know what was going on. So the depression would continue," says **Jane Palermo**, RN, care manager for the depression program.

The health plan developed clinical guidelines for depression and distributed them to the primary care physicians along with copies of the Patient Health Questionnaire or PHQ-9, a short screening tool for depression and a one-page educational flyer on depression.

The PHQ-9 forms and fliers are displayed in the examining rooms.

"If the doctor feels someone is depressed, they go through the survey. Sometimes, patients who are waiting for the doctor to come in look at the survey wonder if they have depression and start a discussion with the doctor," Palermo says.

Physicians make the majority of referrals from the program, although some come from Fallon's disease management programs.

Palermo follows up with the patients as soon as she gets the referral. She screens the members using the BDI to establish a baseline score and follows up with the tool at intervals to track the outcomes.

Many of the members referred to Palermo, particularly those in their late teens and early 20s, have concerns about taking medication.

Palermo follows up with them and tries to build a rapport. The fact that she is calling them on the telephone makes the interventions less threatening, she says.

In many cases, these members eventually start taking their medication and tell Palermo they wish they had done so sooner.

"So many people don't understand that depression is genetic. They see a stigma attached to the diagnosis of depression. They've lived with depression all their lives, and once they take their medication, they are amazed that it's treatable and that they don't have to feel so bad," Palermo says.

In a typical case, she follows up with members about two weeks after they start their medication, and then calls them monthly.

"I always tell them not to wait for me to call if they have a question or a concern. They do call, particularly in the winter months, when they sometimes think they need more medication. Others call just to check in," Palermo adds.

One challenge with patients taking antidepressants for the first time is to help them cope with the side effects, most of which subside after a while. Some members get extreme headaches from their medication. In these cases, Palermo checks with them frequently and, if the headaches continue, calls the physician for a new medication.

"It usually takes three to four weeks before we see any major results. Sometimes patients call in a couple of weeks and think the medication is already starting to work. They feel better just knowing something is going to help them," she says.

There is no particular cutoff time for the program. Palermo follows the members until she and they both feel that they can manage on their own.

Some of the members are in the program only for a short time, such as the man who became depressed after his wife died and stayed in the program only a few months.

"I told him to call me if he ever needed me and we'd reactivate him," Palermo says.

Because of her relationship with the physician offices, Palermo is able to find out answers for the members in a hurry. "A lot of times, patients get frustrated calling the physician and waiting on hold or waiting for the call to be returned. I have a direct link to the physician offices," she says.

For instance, if a patient reports starting to go into a slump, Palermo calls the physician and asks if the medication can be increased. She calls the patient back when the new prescription has been called in to the pharmacy.

In some instances, Palermo recommends that patients get outside help from a psychiatrist to keep their depression in control. She gives them names of psychiatrists to consider and will help them set up appointments if they have difficulties.

"Sometimes, they need more than just the medication and follow up. They need somebody to tie them into the resources they need," she says.

Before the program started, Palermo visited the physician offices to let them know about the program and how they can make referrals.

"It helps increase the rapport when we meet face-to-face. It's not like I'm a stranger to the doctors. I work closely with the primary care providers. They work with me and I work with the patients," she says. ■

3-pronged approach to DM wins award for health plan

DM, CM, concurrent review work together

Great-West Healthcare's disease management approach won the Denver-based company the award of best disease management program in a national PPO for 2002-2003 from the Disease Management Association of America (DMAA).

"The DMAA award represents our commitment to working with providers and members to manage chronic diseases. We were unique among programs that received awards. While others were cited for managing specific diseases, we got an award for our entire program," says **Terry Fouts**, MD, chief medical officer.

Since beginning the programs three years ago, Great-West Healthcare has experienced a reduction in bed days, an increase in physician visits, and pharmacy compliance among members in the disease management program.

The company's integrated Medical Outreach℠ program, which includes disease management, complex case management, and concurrent review, has garnered a 7% net savings and a 2:1 return on investment.

Great-West Healthcare's disease management program covers a number of conditions and diseases. The company offers chronic condition management for members with asthma, diabetes, and cardiac conditions. Neonatal care management and oncology management also are offered. More programs will be added in 2004, Fouts says.

The health plan focuses its chronic condition management on the three diagnoses that drive nearly 80% of its costs, according to Fouts.

"The second reason we picked them is that we realize this is an area where we can support members and physicians in health care delivery transactions. These are chronic diseases that require a lot of patient self-management and a lot of education. There is a lot that goes on between appointments," he says.

The company has outsourced the acute care portion of its neonatal care management to Paradigm Health Services and has partnered with Quality Oncology for its oncology management services while the member is in active treatment.

Paradigm case managers go on-site to manage Great-West Healthcare members in the neonatal intensive care units and feed information to the

company's case managers on a daily basis. When the infants are released from the hospital, the neonatal case managers in each region take over the care.

Quality Oncology handles the members' care between diagnosis and recovery. Once the patient's acute treatment is completed, the Great-West Healthcare case managers take over managing the care.

Primary nurse model

Great-West Healthcare uses a primary nurse model, which means that in most cases the member deals with a single nurse case manager. The nurses are generalists who undergo special training in managing the care of people with chronic diseases.

"When members are in any of our case management or disease management programs, they deal with an individual nurse whenever they are available. If the member interacts with the same person, it makes a better program," he says.

In addition to educating the members about their conditions, the Great-West Healthcare disease management initiatives make sure the patients are engaged with their physicians and that they are compliant with their medication.

"As a physician, I realize that I can't be with a patient every minute of every day. Great-West Healthcare is trying to be a supportive resource for members and for physicians," he adds.

Many people with chronic diseases tend to put off seeing the physician even though indicators, such as an increase in blood sugar level for diabetics or weight gains for those with congestive heart failure, show that they should seek medical attention, Fouts says.

"We try to get them to re-engage with their physician when these indicators occur, even though they may not have an appointment for a month or two," he adds.

Other members have prescriptions that they don't fill or don't refill.

Members are identified for the program through clinical and pharmaceutical claims.

Some are referred from physicians. Others come through internal referrals.

"At Great-West Healthcare, we integrate health care delivery the old fashioned way — we sit next to each other. In each of the regions, the case managers, disease managers, and concurrent review nurses sit together," Fouts adds.

For instance, if a case manager is coordinating the care for a member in the hospital who has been newly diagnosed with diabetes, she will refer the member to the disease management staff. "Because we approach our clients a little differently, I am often in front of our clients. We have a good relationship with the human resource directors and we also get referrals from them," he says.

Members who are identified for the program are asked to complete a health risk appraisal questionnaire on-line, over the telephone, or with the help of a nurse. The health risk assessment takes about 20-30 minutes.

"We can look at the claims to stratify the members, but no computer tells you whether or not somebody understands their disease. That kind of information comes out in the discussion with the nurse," Fouts says.

Those who are stratified in the mid-to-high levels receive a call from a nurse who goes over their condition with them and discusses what they need to do to keep the disease under control.

"The stratification predominately focuses on how well they understand their illness. They could be newly diagnosed with diabetes and not understand the condition. They would need more intensive care immediately and then they could be reclassified," Fouts says.

Those who need only occasional interventions receive information through the mail, educating them about their disease and giving them a number to call for more information.

Members in the middle level need some person-to-person attention and get a telephone call from a disease management nurse.

High-level members with intense needs receive more frequent interventions and may receive equipment such as a scale or a glucometer if they need it.

The member and the nurse case manager agree on a plan, which the nurse takes to the physician for his or her approval.

"It's a three-way relationship — the member, the doctor, and the health plan," Fouts says.

The disease management nurses call the members at regular intervals, depending on the care plan and the member's needs. For instance, if a member says he or she is going to quit smoking, the nurse calls in a few weeks to see how it's going.

"The frequency of telephone calls they receive varies, depending on the member. A diabetic who is not obese and not a smoker wouldn't be called as frequently as someone with a lot of comorbidities," he says.

"Generally nobody has just one thing to manage. Diabetics often have high blood pressure,

obesity, and maybe depression," Fouts says.

The nurses make notes of their conversation during each call and follow up on those notes when they call again. For instance, if a member needs to lose weight, the nurse will ask if the information on grocery shopping helped. The member may say that his family isn't cooperating. The nurse will bring the subject up during the next conversation.

"Every disease management program is based on the Prochaska readiness to change model. [James Prochaska, PhD, a professor of clinical and health psychology at the University of Rhode Island, has written extensively about readiness to change and has developed a model for it.] Members are ready to change at different rates so the nurses work around that as well. We know that just making contact doesn't necessarily mean the patient is going to do everything he or she needs to do," Fouts adds.

The program currently is an opt-in program in which patients have to agree to join. Great-West Healthcare plans to change to an opt-out program over the next year.

"One reason we're moving to opt out is to get a higher participation level. I've seen statistics that show that in an opt-in model, 35% is a good participation rate; but if the member has to choose to opt out of the program, you get a 92% enrollment because you have a hook on them," Fouts says.

One challenge in recent years has been to steer members who are researching their conditions toward valid medical advice on the Internet.

"There are about 35,000 web sites that address health topics. Some are at best borderline and at worst misleading. We want our members to have access to information that has been reviewed at an academic center instead of going to the Internet and just picking any answer," Fouts adds.

The program attempts to steer members toward medical web sites that have clinically valid information about their conditions through links on the Great-West Healthcare web site and written materials sent to members. ■

Couple predictive modeling with DM

System includes clinical alerts, diagnosis risk groups

A predictive modeling program is just the first step in identifying members for a comprehensive disease management program, says **Michael Cousins**, PhD, manager of health informatics for Health Management Corp. (HMC), based in Richmond, VA.

"A predictive model program is necessary, but it's not sufficient to obtain positive outcomes unless it is coupled with a robust disease management program," adds Cousins, who is primarily responsible for the development and testing of the predictive models for HMC's award-winning Healthy Returns℠ System, which delivers targeted individualized interventions to members in the company's disease management programs.

The system received an Innovation in Quality Care and Patient Safety in a Health System Award from the Healthcare Delivery Solutions Congress.

The heart of its Healthy Returns℠ System is Health Management Corporation's proprietary AccuStrat predictive model that uses medical claims information from its clients to identify members with chronic conditions and assign risk stratification for future use of health care resources.

Health Management Corp.'s clients are large employer groups, managed care organizations, and state Medicaid and Medicare organizations.

The AccuStrat predictive model is a hybrid among typical risk stratification models, according to Cousins.

It includes both clinical alert algorithms, which identify members who are not complying with disease management treatment regimes, and diagnosis risk groups, which tabulate the relative risk of the need for future health care interventions.

The AccuStrat predictive model takes hundreds of different elements and comes up with a single score that is used for the overall ranking. Both components, the clinical alert algorithm and the diagnosis risk algorithm, are combined to predict the risk of each individual, Cousins reports.

"A single risk stratification model can predict the severity of disease in an entire population, but it tends to break down if it's used for medical management," he says.

The model uses 144 diagnosis risk groups and computes the relative risk of each disease, then assigns a risk score to the member, taking into account any clinical alert algorithms.

"Our goal is to find people before their care gets expensive. We're looking for people who have conditions or events that indicate they will have future, more expensive events or conditions and higher utilization," Cousins says.

For instance, the predictive model identifies

people who have diabetes and are at risk for an amputation by examining, among other things, pharmacy use and physician visit for issues related to circulation.

Diabetes, congestive heart failure, asthma, cardiac conditions, chronic obstructive pulmonary disease, and asthma are the primary conditions that HMC manages, along with more than 20 secondary conditions that typically are comorbidities. For instance, the company manages obesity and hypertension along with diabetes.

Once the members are risk stratified, the information is loaded into the clinical management tool, which includes overall risk scores, comorbidities, and a patient profile that includes information about prescription history, tests that are indicated but haven't been done, and physician visits.

"Our system's goal is to find everyone with a condition so we're loose enough to find everybody but tight enough not to have a false positive," Cousins says.

HMC uses the clinical alert algorithm as a basis for intervention as well as to identify high-risk members.

For instance, the AccuStrat program breaks out members who have indicators of noncompliance, such as not refilling prescriptions in a timely manner or not having tests or procedures that are recommended in clinical protocols.

Members whose overall risk score falls below the threshold for individual disease management receive a letter reminding them of what they need to do to manage their disease. The company also sends a letter to the primary care physician, alerting him or her that the patient is not following the protocol.

"Every members identified with one of the chronic conditions receives a single risk score. If the score is above a certain amount, they are identified as high risk and go into the high-intensity disease management program," Cousins says.

The Healthy Returns℠ System identifies members who are eligible for the disease management program and flags pertinent clinical information for the disease management nurse. For instance, if a member hasn't refilled his or her prescription, or a diabetic hasn't had a hemoglobin A_{1c} test in more than a year, the information appears in red.

The new system has resulted in fewer inpatient admissions and shorter lengths of stay, he adds.

"We have been tracking the outcomes before and after using the AccuStrat predictive modeling system and have gotten improved outcomes. The only problem is that the results are confounded by the fact that we implemented our third-generation clinical management system at the same time," Cousins says. ■

When providers come bearing gifts, should case managers accept?

Take care to avoid appearance of ethical problems

By **Elizabeth E. Hogue**, Esq.
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When it comes to accepting cash payments from providers in exchange for referrals, there is no question: It is expressly forbidden. But what happens with noncash items, such as the seemingly innocuous gifts that show up around the holidays or the New Year. What are the rules?

The answer is, there are no hard-and-fast rules about nonmonetary gifts to case managers. But that doesn't mean that case managers can accept anything of any value freely and without giving thought to the ethical or legal consequences. Case managers must be aware of the laws surrounding this issue and should reflect upon their own ethical policies regarding accepting any gift — regardless of value — from providers to whom they make referrals.

There is a federal statute that prohibits illegal remuneration or kickbacks and rebates in Medicare and Medicaid and other federal and state health care programs. Providers who offer or give anything to anyone in order to induce referrals violate this statute. Case managers who receive items from providers who want referrals may violate this law and may be guilty of criminal conduct, which could result in jail, fines, or civil monetary penalties.

That raises the ethical question for case managers: What can be accepted from a provider without violating any regulations? Is a free coffee mug the same as accepting, say, a DVD/CD player?

The Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services has stated that regulations will be published sometime in the near future to help define what items of non-monetary value may be accepted from providers who receive referrals. Until that time, however, I believe case managers should follow the Stark laws, which technically apply only to physicians. In essence, these regular regulations prohibit physicians from referring Medicare/Medicaid patients to any facility or firm with which the physician has a direct or indirect financial interest, with some exceptions.

Some guidelines

With the Stark laws as a guideline, case managers conceivably could accept free items of a relatively low monetary value if these are provided within reasonable limits. Viewed this way, a coffee mug is unlikely to cause the case manager to overutilize a certain provider. Here are some guidelines to keep in mind:

- The annual aggregate value of nonmonetary gifts should not exceed $300.
- Providers that give nonmonetary items must provide the same items to case managers who make referrals and case managers who do not.
- Compensation is not determined in any way that takes into account the volume or value of referrals to the provider.

Case managers also should not ask providers for items consistent with Stark law guidelines that prohibit solicitation. Further, the exception for nonmonetary compensation up to $300 only protects gifts to individuals.

Until the OIG issues its regulations, the Stark law will likely provide guidance for case managers. Case managers would do well to continue to monitor developments in these regulations.

In the meantime, however, case managers may want to consider an even stricter guideline: the "no-gift rule." Prohibiting the receipt of any item — no matter how large or small — from a provider eliminates any question. Case managers may wish to post a "no-gift policy statement" in the discharge planning area.

Case managers need to reflect on these issues. Is it necessary for providers to give anything? Why can't a meeting be held with a provider without lunch being paid for? This is the essence of what I call the "no-crumbs approach" — services can be discussed without the "crumbs" of eating lunch involved. The focus is on business discussions that are conducted in an environment in which professionals can communicate with each other without any unnecessary distraction.

While the no-gift/no-crumb policies may seem harsh, I believe they go a long way to sending an important message to providers: The relationship with case managers is purely professional.

In its column, the CCMC explores ethical issues for various areas of the case management field. They welcome your questions and feedback by contacting them at info@ccmcertification.org.

[Editor's note: Elizabeth E. Hogue, Esq., is a Burtonsville, MD-based attorney who is an expert in case management issues. The CCMC has awarded the

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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

11. According to Sam Toney, MD, and Cheri Lattimer, RN, of Health Integrated Inc., medical directors can support case managers in what ways:
A. Pharmacy monitoring and experimental treatments
B. Intervening with primary care physicians
C. Reviewing troublesome cases and dealing with rare illnesses
D. All of the above

12. Care Choices HMO Case Management program deals with high-risk patients while disease management handles patients who have their chronic disease under control.
A. True
B. False

13. Members in Fallon Community Health Plan's depression management program have shown what percentage reduction on the Beck Depression Inventory scale?
A. 25%
B. 76%
C. 82%
D. 10%

14. Great-West Healthcare's Health Risk Assessment screening tool takes how long to complete?
A. Five minutes
B. 10-15 minutes
C. 20-30 minutes
D. An hour or longer

15. How many diagnosis groups does Health Management Corp. use in its predictive model?
A. 56
B. 144
C. More than 200
D. 90

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