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Program to reverse heart disease shows 76% reduction in hospital stays

Case managers are glue that holds the program together

At Highmark Blue Cross Blue Shield, case managers are a vital component of the company's Dr. Dean Ornish Program for Reversing Heart Disease.

"The case manager is the glue that holds the multidisciplinary program and the team together," says **Janet Banaszak**, RN, CCM, national psychiatric consultant and director of case management.

The Ornish program involves lifestyle modifications designed to benefit people who have coronary artery disease or are at risk for developing it.

A multidisciplinary team works with participants on four components of the program: exercise, stress management, group support, and diet.

"The nurse case managers really support the patients. Their role is to monitor their medical status at all times, assess their progress, and work with them to determine what they need to do to be successful," Banaszak says.

In the two-year follow-up period after they have completed the program, Ornish participants have achieved a 76% reduction in hospital stays for cardiac events.

The Ornish group experienced an 87% reduction in myocardial infarctions compared to a 48% increase for a matched control group. Similar findings were documented among Ornish participants for angioplasty (down 84%), bypass surgery (down 80%), angina (down 78%), and cardiac catheterization (down 64%).

"We follow the patients for two years and find better results during the second year. The longer they stay on the program, the more benefit they get," Banaszak says.

Here are some of the other outcomes:

- Participants lost an average of 11 pounds.
- Their systolic blood pressure dropped by 9.7. Diastolic blood pressure decreased by 6.4.
- Cholesterol levels decreased by 13%.

• Depression scores dropped by 44%.

Highmark became the first insurer to provide and pay for the program for its members at the behest of **Anna Silberman**, a company vice president who was convinced that the program could help Highmark members take control of their own health.

"Highmark has always been on the forefront of wellness. Representatives of the company spoke to Dr. Ornish and studied the research and concluded that the program was a very conservative and non-invasive way to make significant health strides," she says.

At first, the insurer offered the program only at its Pittsburgh headquarters, but the initial outcomes were so impressive, Highmark expanded it to other states. The company now offers the program at 16 sites in Pennsylvania, West Virginia, and Illinois, and will begin offering the program in Minnesota this year.

In most cases, several insurers work together with a local hospital to offer the program.

Highmark's Ornish program was cited for its valuable clinically based outcome data and efficacy in 2003 at the annual "Best of Blue" National Awards for Innovations and Best Practices in Medical and Pharmacy Management.

The program also was recognized in the first BlueWorks Quarterly Report, a collaboration between Blue Cross and Blue Shield and Harvard Medical School researchers to highlight innovative partnerships with health care professionals.

The program targets members who are contemplating bypass surgery or angioplasty but would like alternative options; members who have had one or more heart procedures; members diagnosed with coronary artery disease; members who have significant risk factors for developing cardiovascular disease, such as high serum cholesterol levels and a strong family history of heart disease; and members who have diabetes.

Patients may be referred by physicians, by self-referral, or by case managers or other staff within Highmark.

Members who don't meet the criteria but still are interested in the program may self-pay.

When a member expresses an interest in the program or is referred, he or she receives a health assessment questionnaire in the mail.

"We screen the members carefully to make sure they meet the criteria and to get an overall idea of their general health to make sure they're able to do the program. The exercise component is moderate, but we want to make sure they can complete it," Banaszak says.

When a member is identified as eligible for the program or expresses an interest in joining it, the nurse case manager usually is the first person to whom they talk. The case manager interviews the members, takes a health history, and helps them decide if the program will be appropriate for them.

Members who sign up for the Ornish program attend sessions four hours a day, twice a week for 12 weeks, usually at a local hospital that partners with the insurer to offer the program.

The nurse case managers accompany the patients through the entire program.

"The nurse case manager role is vital. There is some research that suggests a relationship between outcomes and the nurse case manager. Studies have shown that a nurse case manager can decrease the

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Editorial Questions

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

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number of hospital admissions, decrease length of stay, and decrease the number of emergency room visits," Banaszak says.

Members receive a psychosocial screening when they join the program, after 12 weeks, and after one year. "We see wonderful results from the psychosocial screening. After the first 12 weeks, there's an improvement in depression, decreased hostility, and improved quality of life," she reports.

Members with significant psychosocial issues are referred for treatment before they enter the program.

The case managers typically work with about 50 patients at a time. Usually about 15 members attend the biweekly sessions. The rest have completed the program.

All of the team members undergo extensive training that helps them understand how the program works, their role, and the role of the other team members.

In the Ornish program, all of the team members chart on their specific modality. The nurse case manager coordinates the documentation and makes sure the other team members are completing their documentation.

The nurse case manager's main role is the safety of the patients. They constantly assess to make sure they are doing well and talk to them every time they come in.

Patients are asked to fill out a personal adherence log, which the case manager checks to make sure they are following the program at home.

If a patient reports any changes in his or her health, such as having angina or feeling that something isn't right, the nurse case manager either gets in touch with the referring physician or takes the member to see the program's medical director.

Banaszak gets in touch with the patients' primary care physicians on a regular basis and lets them know how the patients are doing, sending regular outcomes and progress reports.

"This is a treatment option that does not replace the physician. We work closely with the patients' personal physicians," she says.

Because the program involves such dramatic lifestyle changes, Highmark uses a rigorous screening process to make sure the patients will stay in the program once they enroll.

"We are very clear during the initial interview about what is involved in the Ornish program. The idea is to let them know up front what they will have to do and the benefits of it," Banaszak says.

Patients feel better within the first two weeks of the program, experience a decrease in angina, and lose weight, she notes.

"They start to feel better about themselves, and that is a strong motivator to keep them going," Banaszak adds. ■

Program stresses low-fat diet, exercise, stress relief

CMs support participants to help them meet goals

The Dr. Dean Ornish Program for Reversing Heart Disease is a dramatic lifestyle change for most people who have coronary artery disease or are at risk for the condition.

The program recommends a low-fat, plant-based diet, regular exercise, preferably 30 minutes of brisk walking a day, and stress management techniques that include stretching, meditation or prayer, and progressive relaxation.

"The nurse case manager understands the amount of support the members need to comply. We want them to know they're not in this alone and can always call and talk to someone. Their whole role is to help the members be successful," reports **Janet Banaszak**, RN, CCM, national psychiatric consultant and director of case management.

After they are enrolled in the program, members undergo a physician assessment and meet with their treatment team.

The team includes an exercise physiologist, a certified stress management expert, a dietitian, a group support facilitator who is a licensed counselor, and a medical director for the program at each site.

During the first week of participation, members attend three sessions during which the various team members explain the program to them.

"They let them know why they will be doing the exercises, what stress management does and how stress affects your health, the importance of following the diet, and why this program works. This is when members get a real picture of what they are going to be doing and the importance of complying with all aspects of the program," Banaszak explains.

After the initial week, the participants meet twice a week, four hours a day for 12 weeks.

"The nurse case manager is with them for all sessions, along with the modality specialist for each area of the program," she says.

After 12 weeks, the participants are assessed to see if they need to continue with their on-site participation or if they are ready for the self-directed community. Most stay in the active part of the program for at least 12 more weeks.

The nurse case manager calls the members monthly during the first year to see how the program is working for them. "We make sure they have all the support they need. If they have questions about diet or exercise or anything, the nurse case manager puts them in touch with the appropriate specialist if she can't answer the questions," Banaszak adds.

After the first year, participants join a self-directed community, a group of people who have completed the program and get together to support each other.

The case managers follow the members for another two years after they complete the formal program.

"The self-directed community is what makes our program unique. There is no particular structure. Each group decides how to run their community. They may have a group support session or just meet to go out for dinner," Banaszak says.

The nurse case manager follows up with members during the second and third years of the program.

"We monitor how they are doing medically, if there have been any changes in their medication, or if they have had an event," she notes. ■

Company gains physician support by paying them

Program encourages MDs to work with CMs

The case management department of Blue Cross and Blue Shield of Rhode Island has taken a unique approach to ensuring the physicians will collaborate with their case managers — they pay them for their time.

"Some risk group contracts have a provision that reimburses providers for a 15-minute initial consultation with a case manager. We know their time is valuable, and we feel their input is valuable as well," says **Yvette St. Jean**, RN, BS, CM, operations leader for the case management department.

The physician reimbursement program was rolled out earlier this year.

If a physician agrees to consult over the telephone with a case manager to help develop a plan of care for the member, the company reimburses the physician for a 15-minute office visit.

Whenever possible, the nurse case managers collaborate with the primary care physicians treating the members to develop a plan of care.

"We need to get physician input into the patient plan. We're also hoping that if the physician has a positive experience with the case manager, he or she will refer more patients for case management," St. Jean adds.

Some physicians already are referring members to case management. The insurer wants to increase these numbers as well as the number of members who participate in the program.

Presently, only about three or four members out of 10 who are identified for case management ultimately participate in the program. The case managers are unable to reach some. Others want to get approval from their physicians.

The company is working to identify reasons some members may not want to participate. In some cases, members agree to participate when they are called but become reluctant when asked to fill out the forms.

In many cases, when the case manager contacts members who have been identified for case management, the member wants to check with the physician before enrolling.

"We hope that we can encourage the physicians to encourage the members to participate and that we'll get more members enrolled," St. Jean adds.

The case management department has developed a form to send to the provider in advance of the phone call so they can use their time more efficiently.

For instance, members may indicate that they are confused about the dosage and frequency of their medication. "We include this on the chart so the physician can have any information we need handy when the case managers call," says **Paula Blanchard**, RN, CCM, case management team leader.

Blue Cross and Blue Shield of Rhode Island's case management department was one of the first three Blue Cross plans nationwide to receive the highest accreditation for case management from Washington, DC-based URAC.

"We're most proud of our URAC accreditation. We were the first in the state of Rhode Island to achieve accreditation for our case management department," St. Jean says.

Going through the accreditation process helped improve consistency and assure quality in addition to assuring the members that the program is solid, St. Jean adds.

One of the biggest changes the case management department has made to achieve URAC accreditation has been to dedicate a person to quality improvement.

"We had a good foundation to start with, and going for URAC accreditation helped us to make sure everyone throughout the company was on the same page," St. Jean says.

Triggers for case management

Blue Cross and Blue Shield of Rhode Island's case management department includes 20 nurse case managers and two social workers.

The insurer's homegrown software system was designed so that members who are treated under selected ICD-9 codes automatically are triggered for case managers.

Some of the criteria for inclusion in case management include asthma, diabetes, congestive heart failure, potential for transplant, failure to thrive in infant and children, and prenatal complications.

The system triggers an automatic referral if members are admitted to the hospital twice within a six-month period.

The system also alerts case managers when a member has multiple emergency department visits or multiple hospital visits with a high dollar cost.

The insurer's on-site nurses who handle the concurrent review and work with the discharge planners at the hospitals also help identify members who would be appropriate for case management.

"Right now, we're identifying members for case management after the fact, based on claims data. We want to revise the system to take a more proactive approach," St. Jean says.

When a member is identified for case management, a nurse case manager calls him or her for follow-up.

"The program is voluntary on the part of the members. We offer the program to them and inform them of their right not to participate," Blanchard says.

The software system has an assessment template that the case managers use when they interview the members. The nurse and the member decide together if the member will benefit from the program.

Members receive an introductory packet that includes written consent to participate in the program along with appropriate education materials.

"The nurses encourage the members to sign the consent form and agree to participate," Blanchard says.

"What our nurse case managers offer is education. They also help members find external resources they can utilize for services that we don't cover," she adds.

Two of the nurse case managers are specialists in managing the care of pediatric patients. One case manager is assigned to transplant patients and two to prenatal care.

"The rest of the nurse case managers handle a mix of patients, but some also have specialties. For instance, we know that some nurses are stronger in cardiology, so we triage those cases to them," Blanchard says.

The social workers help the nurse case managers find community resources and help members with their psychosocial issues.

The first social worker was hired to work with the Medicaid population. The plan has begun using social workers for all lines of business and is recruiting for an additional social worker.

"They are of tremendous value to our program. There are so many issues that affect our members that the social workers can help with," Blanchard reports.

The nurse case managers and social workers have weekly meetings with one of the medical directors and a psychologist to discuss difficult cases. "The team gets together and brainstorms about how to manage their patients," she points out.

Until June 2003, Blue Cross and Blue Shield of Rhode Island had a separate case management department for the Medicare + Choice members. Case management services for all of the company's product lines have been combined and all the staff cross-trained.

"We spend a lot of time educating the staff on member benefits and regulations that apply to the Medicare population and might be different from other populations, such as the rules issued by the Centers for Medicare & Medicaid Services," St. Jean says.

When the company's case management department was established in 1997, there were fewer case managers and no sense of direction, Blanchard notes. "Different case managers contacted the members and asked different things. It was confusing to everyone," she says.

One of the first steps was to design assessment templates for all the case managers to follow so everyone was collecting the same information about each patient.

The department is working to come up with some outcomes measures to demonstrate return on investment, cost savings, and improvement in members' quality of life.

"The software system we have documents everything in case notes, which makes it difficult to come up with outcomes unless you manually abstract the data," St. Jean says.

The case management department has good results from patient satisfaction studies but wants to be able to put a dollar figure on its achievements.

The nurses do a lot of disease-specific education and work with members on medication compliance. "It's hard to put a price tag on changing someone's behavior," St. Jean adds.

The department struggles with state regulations that limit some of the utilization review activities the case management department can do for publicly funded members.

For instance, in the past, when a member received home care or needed durable medical equipment, the case managers could coordinate it. Now, under Rhode Island law, the requests for durable medical equipment and home care for publicly funded members have to be sent to a separate department for authorization. ■

DM programs reap rewards for insurer and members

Nurses work closely with regional case managers

Centralizing all of its disease management programs has paid off for Aetna.

The insurer, based in Hartford, CT, won the Best Disease Management Program in Managed Care award from the Disease Management Association of America (DMAA).

The company was cited for its Healthy Outlook Program Caring for Congestive Heart Failure, which it conducts nationally in conjunction with LifeMasters Supported Self Care, an Irvine, CA-based disease management company.

Aetna's congestive heart failure (CHF) program received the DMAA award for demonstrating organizational commitment to disease management, employing science in the design and implementation of the program, and for the favorable outcomes that have been measured using a carefully designed methodology.

Until 1998, Aetna had a variety of disease management programs with regional variations.

"We consolidated our programs in 1998 to take advantage of best-in-class practices, standardize our approach across the regions, and make our programs industrial strength. Because we support patients all over the United States, we've designed our programs carefully to achieve consistent quality results that demonstrate real value to our customers from Texas to New York," reports **Michael Reardon**, MD, national medical director and head of Aetna's Member Advantage Programs.

The company set priorities for its program improvements starting with diabetes and CHF because they are high-cost diseases that affect members' quality of life and because the company has a large population with both diseases. For instance, nationwide, Aetna has about 30,000 members with CHF.

"We started with those two programs because we wanted to get them to the market first and then built our own internal capabilities using the same philosophy and approach," says **Rose Kaufman**, project manager, vendor relations and program strategy.

Aetna chose to use LifeMasters Supportive Self Care, an Irvine, CA-based disease management company, for the CHF and diabetes programs and has developed internal programs for other diseases.

"A cornerstone of the programs' success has been our commitment to a continuous quality improvement approach to disease management. Quite simply, we work every day to make our programs better," Reardon says.

The programs have paid off, he adds.

For instance, members who have participated for at least six months in the CHF program showed significantly improved compliance with an appropriate treatment regimen, fewer emergency department admissions, and shorter hospital stays.

Since the programs began, Aetna's asthma population has experienced a decline in the utilization of hospital services and emergency department visits. Patients with diabetes and coronary artery disease have shown a decline in hospitalization.

"We're seeing an improvement in clinical outcomes and quality of life for members in all our programs," Reardon says.

Rigorous member identification and stratification is another cornerstone of Aetna's disease management program, according to Reardon. "We have gotten very sophisticated with our predictive modeling algorithm that helps us identify patients who need the most help," he says.

Aetna Integrated Informatics, the company's health data division, maintains a huge information warehouse containing 14 terabytes of data that the company uses for the risk stratification and predictive modeling for its disease management programs.

Collaboration between the disease management nurses and the company's regional nurse case managers is a key element of the insurer's disease management efforts.

While Aetna's disease management is centralized, the case managers operate in the company's regions throughout the United States.

"Because we have a centralized utilization management system where all the data about all our members are collected, the internal staff are able to see what is happening with the member on a day-to-day basis. For instance, if the member with diabetes is in the hospital, the concurrent review nurses send the referral to disease management," Kaufman says.

There is a two-way flow of information between the disease management nurse and the case management nurse. For instance, if someone has home care needs, the disease management nurse and the case manager work together.

"They are all on the same platform and can see other each other's cases. It's not unusual for the disease management nurse case manager to confer with the case manager," says **Meg Dee**, RN, manager, Informed Health Line and Disease Management Programs.

The team takes advantage of the "teachable moments" that typically occur when a member has just gotten home from the hospital.

As the case manager works to set up home care services, she confers with the disease management nurse to let her know when the patient is stable enough to be ready for more education.

"When we designed the program, we spent a lot of time creating workflow systems to ensure that there would be a seamless transfer of information between our nurse case managers and the LifeMasters disease management nurses," Kaufman says.

For instance, the disease management nurses in the company's low back pain program focus on preventing re-injury and teaching members first-aid treatment for low back pain.

The nurses in the company's diabetes disease management program focus on helping patients understand and comply with their physician-prescribed treatment plan.

As members are identified for Aetna's disease management programs, they receive a mailing with information on their specific conditions and a telephone number they can call if they have any questions. Patients who are identified as moderately at risk or at high risk in the CHF, diabetes, coronary artery disease, and asthma programs receive aggressive outreach. A disease management nurse calls them to talk about treatment options and provides information to help them make informed decisions. ■

High-risk members are focus of DM program

Members are identified by data, other factors

Aetna's award-winning disease management programs focus the company's resources and nursing skills on the patients for whom it can make the biggest difference.

"We are always looking at other ways to identify members who are at risk so we can initiate interventions to impact the quality of their lives," says **Michael Reardon**, MD, national medical director and head of Aetna's Member Advantage Programs.

The company uses the information in the Aetna Integrated Informatics division's data warehouse to identify members who are at risk for disease and to stratify them as to their risk level.

All members who are identified for the disease management programs are sent an outreach letter encouraging them to call Aetna's disease management line if they have any questions or concerns.

The company focuses its telephonic disease management support on members who are stratified as high risk and others who were not stratified as high risk by the data but other reasons may indicate that they are at risk for an acute episode of their disease.

"The claims and predictive modeling methodology is excellent, but it's not perfect. For example, new members may not have claims experience in our system in the early part of the year. That's why we look for other ways to identify members who

are at risk," Reardon says.

For instance, a member with asthma who was stratified at low risk may call the company's disease management line with a question about a recent asthma attack.

"When someone calls into our disease management line, we do a full health risk screening to identify things in their history that might mean the member is at higher risk," reports Reardon.

Or, a member with asthma may call the disease management line and indicate he or she wants to quit smoking.

If the information from the health risk assessment or the telephone call indicates that a patient would benefit from more outreach and a high-touch program, he or she is switched to a targeted level, Reardon adds.

The disease management nurses call targeted members. "Once we reach them on the phone, the program is tailored to whatever the member needs," says **Meg Dee**, RN, manager, Informed Health Line and disease management programs.

All members in disease management are screened for depression. If they screen positively, the disease management nurses work with the company's behavioral health specialists to get the members into an appropriate treatment program.

The nurses in the disease management program use an assessment tool to identify symptoms, medical issues, and learning deficits the members may have. They use the Prochaska Readiness to Change model to determine how ready the members are to lose weight, start exercise, stop smoking, or change their diet.

"We work on setting mutually agreeable goals with the member and determine the next time the disease management nurse should call them again. We work hard to get buy-in from the member," Dee says.

The disease management nurses focus first on the most critical factors that are identified through the screening process. They emphasize the importance of taking medication regularly, understanding the treatment plan, and being aware of the tests they should have and the results they should get.

"The nurses use their skills and tools to help the member make changes to reduce their health risk. We often hear from members how much the nurses do for them," Dee says.

The disease management nurses provide whatever counseling and support the members need on an ongoing basis.

"Our aim is to improve the quality of life for our members with chronic diseases," Reardon adds.

As the members meet their goals, the nurses will contact them less frequently.

Aetna sends all members a disease-specific newsletter twice a year and includes a telephone number they can call with questions.

The company's programs take a member-centric approach to disease management.

"We want the members to know their disease, to know the numbers that are meaningful for their disease, such as their cholesterol or hemoglobin A_{1C} numbers. We make sure they understand their treatment plan prescribed by their physician and know how to take their medication appropriately," Reardon says.

DM program lowers costs and improves health

Program uses expert vendors for DM

When PacifiCare Health Systems Inc. decided to expand its disease management programs, the Cypress, CA-based insurer looked at all the options and decided to contract with vendors who were experts in their field rather than developing the comprehensive programs in-house.

"Our philosophy is that if there is significant specialization required for a particular type of program, we prefer to outsource it. Building a really good program takes a long time and a lot of money, and that has to be factored into the decision," says **Kathy Cartelli**, director of disease management.

Their philosophy must work. The Disease Management Association of America awarded PacifiCare its prestigious Excellence Award for demonstrating favorable health outcomes and improved quality of life for its Medicare + Choice members with congestive heart failure, coronary artery disease/stroke, and chronic obstructive pulmonary disease.

The company has been awarded a demonstration project from the Centers for Medicare & Medicaid Services (CMS) to provide specialized disease management services and comprehensive drug coverage for 15,000 chronically ill Medicare fee-for-service beneficiaries in California and Arizona who have congestive heart failure.

The insurer has seen significant improvement in health outcomes for members who participate

in disease management programs as well as substantial cost savings, according to **Gordon Norman**, MD, PacifiCare's vice president of disease management.

"We designed our disease management programs to help improve clinical results, better treat diseases, and help alleviate our members' pain and suffering with an overall goal of enhancing the care and quality of our members' lives," he says.

PacifiCare launched its first disease management programs in the mid-1990s. "In 2000, we began to take a different approach, spurred by changes in how we contract with network physicians. We were starting to move away from capitation and to bear the risk for health care costs ourselves and were looking for additional strategies to control health care costs and still provide high-quality care for our members," Cartelli says.

After looking at a lot of options, including creating the programs in-house, PacifiCare selected a number of disease management vendors who specialized in managing particular chronic diseases.

"We didn't go to one company that offers 30 programs. Instead, we decided to take a look at individual diseases and choose the best interventions for each one," Cartelli says. **(For more on the advantages of outsourcing disease management and tips for choosing a vendor, see related article on p. 47.)**

Initial programs

The company currently has contracts with seven different vendors.

PacifiCare Health Systems started its disease management initiatives with four Medicare + Choice populations with which they have the biggest opportunities for improvement. Their initial programs, rolled out in late 2000 and 2001, were for congestive heart failure, coronary artery disease, stroke, chronic obstructive pulmonary disease, and end-stage renal disease.

The company chose vendors who offered services in each of the states where it provides coverage so the programs in each state will be the same.

By the end of 2003, PacifiCare added a cancer program, a neonatal intensive care program, and an orthopedic case management program.

Cartelli attributes the success of PacifiCare's disease management programs to making sure the members who will benefit are identified and enrolled, educating primary care physicians on the program, and closely monitoring the vendors.

"We are heavily involved in making sure that we get the most out of our programs. We carefully track clinical outcomes and work with the vendors to develop strategies for program improvement," she says.

When PacifiCare analyzes program outcomes, the company looks at the total population of people eligible for the program, rather than just those who are participating.

"We don't want them just picking off the low-hanging fruit. We want to make sure that they picked the right people for interventions. If you measure disease-specific costs and all costs, you can really see if there is an impact," she says.

Identifying members

The company encourages the vendors to focus on enrolling members, particularly in some programs.

It's easy to find and enroll members with end-stage renal disease because they are in a dialysis center three days a week, Cartelli points out.

"In comparison, asking someone with congestive heart failure to put a scale in their home and monitor their weight is more difficult. Our enrollment rates vary with populations," she adds.

If Cartelli doesn't feel as though a vendor is enrolling enough people in a particular program, she works with it to develop strategies to address the problem.

Members who are eligible for the program are identified from pharmacy data, hospital and physician claims data, and other authorizations. Referrals come from the concurrent review staff, physicians in the PacifiCare network, and case managers.

"The entire organization works to help make these programs work by early identification of potential enrollees. We look at claims data every month and identify people who potentially have the various chronic conditions and who may benefit from our program. We work with the disease management vendors to provide outreach for the members," Cartelli says.

The disease management vendors are responsible for contacting the members, confirming that they are eligible for the program, and enrolling them.

PacifiCare monitors the data to determine the outcomes and the success of the programs.

"We've been successful because of our constant oversight of the process and because we are always

working with the vendors to see where improvements can be made," Cartelli says.

Each month, Cartelli examines the data PacifiCare gets from vendors, looking at how the disease management programs are progressing in each market and what benchmarks are or are not being reached.

"We track utilization during the contract period and compare it to utilization during the baseline period, making adjustments for unit cost changes. We want to make sure we are really judging the impact of the program and want to account for the possibility that more or fewer members are involved," Cartelli says.

Two strategies

All of the vendors must follow clinical guidelines adapted from nationally recommended guidelines.

"Before we sign a contract, we look at any guidelines the vendor is using to make sure they fit with our guidelines. If they make any changes in the program, we make sure they still fit with national guidelines," she says. PacifiCare has developed two strategies for improving enrollment:

- Members who are identified as eligible for the program receive a letter describing the program and notifying them that someone will be calling them in a few days.

"We've found this works better than a phone call out of the blue," she says.

- The company also works to educate physicians about the disease management programs, a task that often takes several contacts before it's effective.

"A lot of seniors say they want to talk to their doctor. If the doctor isn't familiar with the program, the likelihood of getting them to enroll is slim," Cartelli says.

"Physicians are so busy that one letter or phone call isn't effective. We use letters, fax campaigns, job aids, and personal meetings to inform them about our programs and the patients that can benefit from them," Cartelli says.

Workflow systems

The company works with the vendors to decide how often members should be contacted. Those in the high-risk groups usually get a telephone call or a visit once a week. "We make sure they're doing what they should be doing and if not, we look for the barriers to compliance," she says.

PacifiCare has worked with the vendors over time to integrate their disease management programs with the company's case management department.

At PacifiCare Health Systems, members who have multiple comorbidities or psychosocial issues are referred for case management.

PacifiCare has set up a workflow system that moves patients smoothly from the vendor-based disease management programs to the company's in-house case management program.

"Typically, someone will progress in a disease to a state where disease management can't help them. They need more coordination of care and interventions that do more than focus on a particular disease. At this point, the disease management vendor closes the case and refers the member to our in-house case management staff," Cartelli says.

Sometimes, members are referred to in-house case managers for short-term help. For example, if a member in a disease management program has experienced the death of a close family member, the disease management nurse may refer him

or her to a case manager who can help with community resources such as grief counseling.

"They talk to each other and make the decision on the best way to handle the situation for each individual member. The case managers and the disease management nurses work closely when members need a lot of care," she says.

PacifiCare Health Systems is in the process of recruiting participants for the three-year Medicare demonstration project that is aimed at decreasing the number of acute hospital stays and improving outcomes and quality of life.

CMS requires the project to be budget neutral, meaning that the money spent on disease management and the savings will cover prescription drugs, Cartelli reports. ■

Plan carefully to ensure DM programs will succeed

Contracting with vendors may be to your advantage

When it comes to disease management programs, **Kathy Cartelli**, director of disease management for PacifiCare Health Systems Inc. recommends hiring experts.

"We put a lot of thought behind the pros and cons of doing it ourselves vs. contracting with vendors. We decided to go with people who have already developed the expertise rather than handling it ourselves," Cartelli says.

An analysis of their patients and claims data indicated that hiring specialists in fields such as oncology and neonatology along with the physicians to support the program would not be cost-effective, she adds.

In addition, like other entities in the health care industry, PacifiCare has faced a nursing shortage in many states where it provides coverage and foresaw the difficulty of finding enough staff to support the program.

"The vendors have large staffs, including the medical directors, nurses, and others who have expertise in each particular disease," Cartelli says.

When insurers develop their own disease management programs, they have to design comprehensive data systems and workflow management systems to do the job well, she says.

When the programs are outsourced, if you don't get the performance you are looking for, you can always choose another vendor, Cartelli points out.

Doing the homework

Before choosing vendors for their program, the PacifiCare team went to industry meetings to learn about disease management programs and talked to representatives from other health plans to find out their experiences with various vendors.

"We would typically invite three or four vendors with expertise in a particular disease to come in and talk to us about what they could do. If they could meet what we were looking for, we would narrow it down from there," Cartelli says.

Before signing the contract, the PacifiCare representatives conducted a thorough investigation of each vendor, including making site visits, checking references, and studying each company's financial statements.

Here are some other ways to ensure that your disease management program will work:

• Decide on specific goals for the program before you talk with vendors.

"Each organization the vendor contracts with may have different goals. That's why they need precise information about the type of program you're looking for," Cartelli says.

If you know what you want to accomplish, you can set your expectations and the vendor will

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know in advance what it has to do to meet them, she adds.

• **Include performance metrics**. The vendor needs a way to show if the program is successful.

• **Track both financial and outcomes data.**

Cartelli suggests including measure such as clinical indicators, utilization data, and member satisfaction information. ■

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

16. Participants in Highmark Blue Cross Blue Shield's Dr. Dean Ornish Program for Reversing Heart Disease achieved a ____ reduction in hospital stays for cardiac events.
A. 30%
B. 76%
C. 50%
D. 10%

17. The case manager in the Ornish program works with members and the entire treatment team. What disciplines make up the treatment team?
A. Dietitian, primary care physician, physical therapist, counselor
B. Exercise physiologist, facilitator, stress management expert
C. Psychologist, occupational therapist, fitness coach, dietitian
D. Exercise physiologist, dietitian, stress management expert, facilitator, medical director

18. If a physician agrees to consult with a case manager over the telephone, Blue Cross and Blue Shield of Rhode Island pays the physicians for a 15-minute office visit.
A. True
B. False

19. Aetna's consolidated disease management program for congestive heart failure targets ____ patients nationally.
A. 10,000
B. 50,000
C. 30,000
D. 12,000

20. PacifiCare Health Systems has contracts with ___ vendors for its disease management programs.
A. 7
B. 3
C. 10
D. 0

Answers: 16. B; 17. D; 18. A; 19. C; 20. A.