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Case Management ADVISOR

Covering Case Management Across The Entire Care Continuum

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AMERICAN HEALTH CONSULTANTS

IN THIS ISSUE

AUGUST 2004
VOL. 15, NO. 8 • (pages 85-96)

Wireless technology connects case managers with referral sources

Community agencies join to serve the uninsured

Thanks to wireless technology, case managers working in Chicago's poorest neighborhoods no longer have lengthy waits to get referrals to other agencies for their clients.

Now, when they locate a client or potential client in the field, they have instant access to information about that person and can be in immediate touch with other community agencies that provide services to the medically underserved.

Access Community Health Network, Chicago's largest provider of community-based primary health care, created a technology-based adherence program with a grant from the U.S. Department of Commerce.

Access Community Health operates 40 health centers in Chicago and its suburbs, providing primary preventive care and HIV case management to 300 HIV-positive patients.

The system links Access with seven other community agencies that make up West Side Collaborative Care, a coalition formed to increase access to health care for people at risk of HIV/AIDS and other sexually transmitted diseases, tuberculosis, and substance abuse disorders.

The Client Adherence Referral Electronic (CARE) system integrates a case management referral and tracking software system with wireless sub-notebook personal computers and special message-routing technology.

Coalition members can access the software in the office, at home, or in the field with their wireless sub-notebooks. Case managers in the field have instant access to client information on the computer. They can enter or access client demographics and assessments and make referrals on the spot. The data they collect in the field are wirelessly uploaded into the master database for immediate client update.

Using the CARE system, case managers can send a referral to a community agency and get back an answer within a few minutes, rather than making multiple phone calls and faxing pages of documents back and forth.

"One of the barriers to delivering community-based health care in the field is timely communication. This system allows all of the agencies to track referrals of clients and share key information essential to coordinating care and promoting adherence to referrals and treatment plans," says **Angelique Johnson**, director of grants management for Access Community Health.

The wireless technology has helped community-based case managers cut referral times from a few days to a few minutes and has helped the agencies eliminate client "double-dipping."

Case Management Advisor™ (ISSN# 1053-5500), is published monthly by Thomson American Health Consultants, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Case Management Advisor**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcpub.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $399. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. For approximately 18 CE nursing contact hours, $449. Two to nine additional copies, $239 per year; 10 to 20 additional copies, $160 per year; for more than 20, call (800) 688-2421. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $67 each. (GST registration number R128870672.)

This continuing education offering is sponsored by Thomson American Health Consultants, which is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Thomson American Health Consultants is an approved provider (#CEP10864) by the California Board of Registered Nursing for approximately 18 contact hours. Thomson American Health Consultants is approved as a provider from the Commission for Case Manager Certification for approximately 11 clock hours.

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The agencies have experienced a 75% increase in case management efficiency, Johnson says.

The web-based software unifies intakes and referrals from the various agencies and creates one client file shared by the participating agencies, says **Abe Miller**, information services manager for Access Community Health Network.

"The software includes a built-in history system, allowing the case manager to view past referrals for services, assessments, and changes to client demographics," Miller says.

Before the CARE system was created, representatives from the eight different agencies collaborated to determine what data the system should collect, with each agency listing the minimum amount of information it needed from an assessment to decide whether to accept or decline a referral, Miller says.

The group came up with 22 questions that every agency uses for its assessment process.

Once a client is in the system, if he or she goes to a different agency, that agency can see demographic information, past intakes, assessments, and referrals.

The case managers who work in the field for all the participating agencies take wireless touch-screen sub-notebook computers with them when they go out to see clients.

They enter clients into the system, complete an assessment, and collect a medical history. If the patient is receiving services from one of the eight agencies and is in the system, the case manager merely updates the file.

Each agency in the collaborative has a two-way pager with a mini-keyboard. The pager numbers are already in the CARE system for each agency. Case managers use this system to facilitate referrals.

For instance, when a case manager encounters a client who needs substance abuse treatment, she enters the information into the system on her computer and gets a list of all the agencies that provide the service.

She chooses the agency that best fits her client's needs, such as a program for females with children, enters notes into the computer system, and conducts an on-line referral in real time.

The system automatically pages the agency by sending a text message on the two-way pager. Then someone from the agency logs into the CARE system web site and has access to client demographics, intake information, and assessment. The system gives them the option to accept the referral, decline the referral, or put the client on the waiting

list. Then the system pages the case manager with the decision. "We've been able to reduce the time we spend communicating back and forth and automate our referral process," she says.

Case managers working in the field need to quickly and easily connect clients with housing, food, and other nonmedical needs, as well as ensuring that they get physician appointments when they need them, Johnson says. They spend most of their time in the field looking for their clients, most of whom are homeless.

Access case manager Katrina Holmes is a specialist in HIV and AIDS prevention case management, Johnson says. When Holmes and other case managers go out with the Chicago Recovery Alliance's needle exchange van, they look for people who would be appropriate for case management and approach them cautiously about seeking medical care.

"Katrina gives out condoms and talks about HIV prevention and gradually builds up a rapport with the clients. Instead of immediately focusing in on their health care needs, initially she works on becoming a friend," Johnson says.

After they build up a rapport with the people, the case managers try to strike up a conversation to open the door to providing additional services.

"A case manager might say, 'It seems like you don't feel well. Would you be interested in coming by the health center? I can schedule an appointment for you now,'" Johnson says.

Recently, one case manager in an outreach van reported that it took less than 20 minutes to make a referral for a new client and receive a response. It took five minutes to add the client into the database, seven minutes to do an assessment and make a referral, and another five minutes to receive a response.

"Before the CARE system, there was a huge gap in communication between one agency and another. There would be requests for information on referrals and service availability back and forth. Sometimes a case manager had to talk to several agencies and wait for a response. This has dramatically impacted service delivery," Johnson says.

In the past, Access case managers would have to write down demographic information and assessment information, then call a treatment center looking for an open bed.

"The problem was trying to get someone. They had to leave a voice mail message or try to page someone in the other agency. It would be hours or sometimes even days before they'd get a response," Johnson says.

The system is particularly helpful in facilitating referrals for a clientele that is transient and likely to change their minds about getting treatment, Johnson points out.

In a typical scenario, a case manager will encounter a client when she's with the Chicago Recovery Alliance. Often the case manager and client have talked for weeks or even months about treatment services, and one day the client is finally ready.

Quick referrals can make the difference

"When they say they're ready to go into treatment, if you have to wait a day or even a couple of hours, you're likely to lose them," Johnson says. "Unless you get someone into treatment right then and there when they say they're ready, 95% of the time you can't find them again."

When the case manager gets a timely answer to the referral, she can arrange transportation to the treatment center and get the clients there before they change their minds.

The system has helped agencies eliminate double- and triple- "dipping" by clients who go to more than one agency for free food and medication.

"If someone is getting food or medicine from several different agencies, they're taking it away from the people who really need it. Before we had this system, there was no way for the other agencies to know where the client was getting services," Johnson says.

For instance, recently a man showed up at Haymarket Center asking for HIV case management and a referral for medical services and housing. When his name was put into the system, it showed that someone with the same name and date of birth was receiving services from Access Community Health.

The Haymarket case manager talked to his case manager at Access, confirmed he was getting services there, and asked the client to choose which agency he wanted to provide the services.

The coalition currently has a software-integrated reminder system in the pilot-testing stage. Within the CARE system, pagers can be set up to send reminders to patients who have a hard time remembering medications or to remind them when they need to come in for medical appointments or group therapy meetings.

"We have HIV patients who have to take medicine multiple times a day. It's often hard to remember to take it every time," Miller says.

The system allows the case manager to pull up the client's file, enter a pager identification code, and set up a reminder. The software prompts the message-routing system to send individualized messages to clients reminding them of appointments or to take their medication, or sending them words of encouragement. Clients can instantly respond to the message, choosing from a list of customized responses. For instance, with medication reminders, the system asks clients if they took the medication, if they need a refill, or if they want the case manager to call them.

The coalition recently gave out 35 two-way pagers to clients to test the system. Early results of the pilot program show that it is working and that clients like it.

"The message is getting out to the clients, the clients can respond, and we can track the responses. We'll be able to look at actual laboratory results and compare them to a client's message response log to see if we are getting increased adherence to the client's treatment plan," Miller says.

The system is capable of sending special messages to remind people of their appointments either through the pagers or through an automatic telephone message system, which Miller hopes to test in the future. ■

Acuity system keeps CM workloads on an even keel

Cases are assigned by needs of members

A system that rates cases by acuity level helps case managers at BlueCross and BlueShield of Oklahoma (BCBSOK) keep their workload evenly distributed.

Cases are stratified by complexity, with Level 1 being the lowest acuity and Level 5 the highest.

"We know that in case management, you can't say that everybody has 42 cases; some may have time on their hands, while others may be working overtime. This system helps the case managers maintain a caseload level that will enable them to provide clients with high-quality, cost-efficient services," says **Kathy Edwards**, BSN, RN, manager of utilization management for the Tulsa-based insurer.

Each case manager carries a load of 40 to 60 cases, depending on the acuity level. Cases are categorized according to the acuity level of case management services, patient needs, and involvement the case manager will have in the case.

For instance, members at Level 1 may need only a weekly or biweekly call. A Level 5 case may be a new patient who is going to acute rehabilitation and needs discharge planning and family teaching, and will need home health.

The case managers do the acuity ratings on their own cases. The supervisor spot-checks as a quality control measure.

"We have identified the number of touches a patient with a particular condition needs based on our past experiences. That information is put into each level," Edwards says.

At the end of the week, the case managers complete their acuity reports and close any cases that are completed. They review the acuity report and change the levels of their cases if indicated. The final acuity report is sent to the supervisor, who enters it into a spreadsheet program designed in-house that takes into account the number and complexity of cases and comes out with an acuity rating for each case manager's workload.

The information goes to the intake nurse so she can make sure she is assigning the new cases to the right case manager. The target is for each case manager's caseload to have a weighted value of 200 or less.

New cases start out at Level 5 because the case managers have to complete an assessment and a care plan.

"It may not be a difficult case, but it's assigned to Level 5 because it takes time to get a new case set up," Edwards says. The case may drop to a lower acuity level by the next week.

The case management department at BCBSOK handles catastrophic injuries and illnesses.

When a member has been in the hospital for seven days, his or her case is assigned to case managers who follow the hospitalization concurrently.

"We want case managers looking at the cases for identification of needs such as discharge planning and other resources," Edwards says.

Among the diagnoses that are triggered for case management are closed head injury, heart attack, stroke, amputation with a need for rehabilitation, traumatic brain injury, and some cancer diagnoses. Other triggers include frequent hospitalization, certain medications, cases that must meet certain criteria to provide medical necessity, and members who need hospice care.

"The cases that are triggered for case management are subject to change. We look at trends and changes in treatment regimes and change the triggers accordingly," Edwards says.

For instance, at one time everyone with HIV was assigned to case management. Now, because of newer medications that keep the disease under control and result in longer life spans, a diagnosis of HIV is no longer an automatic trigger.

The cases come from referrals by providers, self-referrals from members, referrals from customer service, and through precertification. Once a patient's length of stay in the hospital has reached seven days, the case automatically is reviewed by case management.

The BCBSOK case management department has one supervisor and seven case managers, all of whom are certified case managers, except for one who is sitting for the exam this year.

Three nurse case managers coordinate the care for members in the Federal Employee Program. One nurse is an intake specialist who takes care of paperwork and required permission for case management and assigns members to the case managers.

The other three case managers are responsible for the other lines of business and are familiar with those contracts and benefit designs.

When a case comes into the case management queue, the intake nurse assigns it for concurrent review if the patient is in the hospital.

If a new case comes in over the telephone, the intake nurse does whatever is necessary to expedite the case. For instance, if the provider says the member needs intravenous antibiotics in the home setting, the intake nurse will get home infusion services started.

When a member is referred to case management, the case managers contact the member and the provider and complete a detailed assessment that can take as long as two hours.

They take into consideration the needs of patients at home, discharge planning needs while the patients are in the hospital, and whether the patients will need to be managed after discharge.

"There's not just one recipe to determine who goes into case management. We look at a lot of different issues," Edwards says.

Sometimes the case manager may go through the entire three-page assessment form with the provider and the member and conclude that the member does not need active case management, she adds.

The case managers are generalists with a broad range of experience in hospice, home health, medical/surgical, and other areas of health care, and they all handle a variety of cases. The exception is one nurse with specialized training in organ transplantation who handles all the transplant cases.

Most of the case management work is done over the telephone, but when it's necessary, case managers will meet with the member and family in person, either at the hospital or the home.

For instance, when a member has complex discharge needs, such as rehabilitation services, it is more effective for the case manager to meet with the hospital team during discharge planning, Edwards says.

In one instance, when the case manager felt the member was in danger from a caregiver, she met with adult protective services in the home and evaluated the situation.

Savings figured each month

At the end of the month, each case manager figures the cost savings associated with her active cases. The case management supervisor enters the information from each case manager into a spreadsheet.

Among the savings they look at are those that result from a change in intensity of service; a change in the estimated length of stay for inpatient, outpatient, and home care services; savings from coming up with an alternative treatment plan that provides the same quality of care; savings from averted admissions; or a combination of factors.

For example, if a patient in the acute care hospital is medically stable and is moved to a skilled nursing facility (SNF), the case manager notes the difference in the daily rate for the acute care hospital vs. the SNF daily rate and calculates the savings.

Or a patient may be getting intravenous antibiotics in the skilled nursing facility and the case manager determines that the patient could go home with home health services. The case manager then calculates the difference in the cost of care.

The individual reports go to the supervisor, who separates out the cost savings by line of business as well as calculating the average cost savings per patient during that period of time.

The reports go to upper management as well as self-funded employee groups that contract with BCBSOK. ■

Incentives work in disease management initiatives

Program saves $1.6 million in three years

When new members enroll in one of Blue Cross and Blue Shield of Oklahoma's (BCBSOK) health promotion programs, they receive free equipment to help them monitor their chronic disease.

For instance, members in the diabetes health promotion program receive a free glucose meter to enable them to check their blood sugar regularly. Patients with congestive heart failure get bathroom scales to encourage daily weight monitoring. The plan provides peak flow meters for people in the asthma disease management program.

BCBSOK will give away pedometers to encourage an exercise regime for members in the new coronary artery disease program, which went live in April.

Other components of the program include disease case management for high-risk members, classroom education for some diagnoses, coordination with members' physicians, and regular educational materials for members in all risk categories.

Preventive screenings increase

"We have found that our initiatives make a difference financially, and from a clinical perspective," adds **Elaine Olzawski**, RN, MPH, manager of operations for the medical affairs department.

The initiatives must be working. Over a three-year period, the health plan saved nearly $1.6 million in cost of care for people in the health promotion programs. The figure includes total medical costs, not just disease-related costs. The health plan has seen an increase in quarterly hemoglobin A1C checks, foot checks, and eye exams for diabetics and in other recommended preventive care measures for members with other diagnoses.

"We're starting to see some improvement in control of blood sugar. It's not statistically significant yet, but there is some movement," she says.

Potential members are identified through claims and pharmacy data as well as referrals from providers, members, and the company's customer service department.

The health plan's utilization management software sets up an automatic referral process if anyone is admitted to the hospital with asthma, diabetes, congestive heart failure, or coronary artery disease.

"Chances are we already know about that person, but it may be a new member who wasn't in the system the last time we ran the data, or it may be someone who is newly diagnosed. An automatic feed from our utilization management program helps ensure that nobody falls through the cracks," she says.

The health promotion staff at BCBSOK are specially trained nurse case managers who typically coordinate the care for about 500 members, Olzawski says.

When members are identified for a disease management program, they are stratified into risk categories. Low-risk members receive the health incentive tool and are mailed educational materials.

The nurse case managers contact the high-risk members by telephone at intervals that depend on the severity of their disease. They reinforce the educational materials, answer members' questions, and coordinate with members' physicians.

Members with diabetes who are at risk are offered classroom education taught at a diabetes education center certified by the American Diabetes Association. The class focuses on living a full life with diabetes, including menu selection when dining out, adjusting medications, and self-monitoring techniques.

The classes may be individual for Type 1 diabetics and in a group setting for Type 2 members.

The health plan sends reminders to diabetics to schedule screenings such as foot exams, hemoglobin A1C screenings, and eye examinations.

The disease management nurses contact the high-risk members once a quarter to reinforce the educational program. ■

Program cuts LOS, ED visits for kidney patients

Nurses monitor members face to face

A field-based disease management care program in which nurses meet face to face with members with chronic kidney disease and end-stage renal disease has resulted in dramatic decreases in emergency department (ED) visits

and hospital bed days for patients managed by RMS Disease Management Services in Vernon Hills, IL, an affiliate of DaVita Inc.

Hospital bed days for patients in the RMS programs were nearly 45% fewer than those of other patients in 2000. ED visits for RMS patients dropped 75% between 1998 and 2000. In 2001, 93% of RMS patients achieved or exceeded dialysis adequacy targets, compared to the national average of 80%.

RMS coordinates the care of health plan members with chronic kidney disease and end-stage renal disease for health plans across the country. The company hires community-based nurses with extensive nephrology experience who work with the members face to face.

Members in the program participate on a voluntary basis at no extra cost to them.

Achieving member stability and autonomy

"Empowering the members to manage their own disease is the key to the program. The nurses work with the entire health care team, including the dialysis facility, the primary care physician, the nephrologists, and the health plan case managers to coordinate and facilitate care. They also help the members adapt their lifestyles and tap into community resources," says **Dorothy Hailston**, CSN, RN, CNN, director of clinical services for RMS disease management services.

The nurses, called Health Service Coordinators (HSCs), meet with members in their homes, at the dialysis clinic, or in physician offices. Each nurse manages the care of between 80 to 100 patients, depending on geographic location.

"The health service coordinator serves as a means for achieving member stability and autonomy through advocacy, communication, education, identification of service resources, and service facilitation," Hailston adds.

The members are risk-stratified according to comorbidities and utilization of services. The HSC and the member jointly identify issues that need to be managed and develop a plan of care. The plan is delivered to the member and the entire care management team, which may include a nephrologist, multiple specialists, a primary care physician, and the dialysis center team.

Risk stratification drives the frequency of the contacts the HSCs make with the member. The nurses regularly see the patients face to face, but also may telephone them between visits.

"We follow the members very closely, ensuring that the prescribed medical regime, health promotion, and prevention screening are conducted and that all services are delivered. Therefore, the member doesn't fall through the cracks, as sometimes happens in our fragmented health care system," she says.

Comorbidity management is a key to RMS' advanced care model, Hailston says.

About 60% of the members with end-stage renal disease are diabetics. Many also have cardiovascular problems.

The HSCs follows national guidelines for each specific disease and tailor the member's individualized care plan to meet the guidelines. For example, they examine the feet of diabetics at each visit and educate members as well as family members on how to perform a daily self-examination. If the member develops a wound, the HSC will refer him or her to a wound care management program.

The HSCs closely monitor members with a history of congestive heart failure, often speaking with them on a daily basis. They educate the members about fluid and dietary restrictions, daily self-monitoring of weight and blood pressure, and early warning signs of congestive heart failure.

Proactive care avoids hospitalizations

"Through this proactive care and early intervention, hospitalizations are more frequently avoided," Hailston says.

The RMS HSCs work with other case managers throughout the continuum to coordinate patient care.

"Case managers can work hand in hand with the HSCs to reduce overall health care costs and improve outcomes for this fragile patient group. This team approach has proven to be successful for RMS and payers throughout the country," Hailston says.

If a patient is hospitalized, the RMS health services coordinator contacts the hospital discharge planner and collaborates on the discharge plan. Sometimes the treating physician isn't aware that antibiotic therapy can be delivered during dialysis. In these cases, the HSC facilitates the infusion of antibiotics during the regular outpatient dialysis treatment.

The HSC contacts the members after discharge and schedules a home visit.

"The HSCs continue the proactive facilitation of the discharge plan by ensuring that referrals for home health, durable medical equipment, or home infusion therapy are implemented. We

make certain the appropriate care is delivered at the appropriate time by the appropriate people," Hailston says.

The nurses and the patients work together to identify lifestyle changes that can help patients remain compliant. For instance, the health services coordinators teach the members how to choose appropriate food at restaurants so they can go out to eat and stay within their recommended diet.

Since patients on dialysis have to monitor their fluid consumption, the nurse demonstrates during the home visit how much the patient can drink each day by using the member's own glass or pitcher.

"Our nurses open refrigerator doors and cupboards to determine what food sources the member has. They know if the member can afford their medication, their electrical bill, and their food," she says.

During the home assessment, the nurse makes sure the home is safe and the member has no mobility issues. If areas of concern are identified, she works with the member, family, and community to resolve them.

Nurses identify compliance problems

The nurses also work with the patients to help overcome any compliance problems they may have. For instance, some kidney patients habitually skip some of their dialysis treatments. In those cases, the nurse educates the member on the benefits of dialysis and investigates why the member may skip his or her treatment.

Because the HSC builds a rapport with members, she often identifies problems that the member is reluctant to discuss with other providers.

"These issues may be financial or psychosocial. Sometimes people skip treatments to maintain a work life or because they need to be home when the grandchild they are caring for gets home from school. There may be other issues, like transportation," Hailston says.

In these cases, the nurse helps the member access community resources that can help with these types of problems.

The nurses monitor candidates for kidney transplants, ensuring they are referred to a transplant center and that the work-up is complete.

When patients choose to stop dialysis, the nurses educate them on end-of-life issues and put them and their families in touch with community resources such as hospice organizations. ■

Automated system reminds members of screenings

Telephone calls work better than mailings

An automated calling system reminding members to get preventive health care services has paid off for Horizon Blue Cross Blue Shield of New Jersey (BCBSNJ).

Instead of receiving a postcard reminding them to go for immunizations, cancer screenings, prenatal and postnatal care, and other preventive health care services, members who are eligible for the services receive a computer-generated telephone call.

"Through focus groups, we discovered that people don't usually take action on mailed reminders. Telephone calls have a higher success rate in getting people to take action on recommended tests and procedures and are about a third of the cost of mailed reminders," says **Richard Popiel**, MD, MBA, vice president and chief medical officer of the Newark-based health plan.

The program has produced dramatic increases in the number of members obtaining preventive health care services.

For instance, in 2003, Horizon BCBSNJ's HEDIS score for breast cancer screening was 78%, the highest in its market. It has increased to 83% this year.

Cervical cancer screening rates, at 78% in 2003 — about average relative to other health plans — improved by 12% in 2004 to 88%.

Outcomes have improved in the other targeted areas as well, Popiel adds.

The preventive health care call program has won a BlueWorks recognition award, which honors initiatives shown to be effective in improving the quality and affordability of health care among Blue Cross and Blue Shield plans throughout the country.

The call program is part of Horizon BCBSNJ's World Class Clinical Quality initiative that focuses on preventive disease management.

Early recognition of members' health risks and programs that advocate prevention are critical parts of Horizon BCBSNJ's corporate strategy, Popiel says.

"We looked at what we were doing as a health plan and determined its effectiveness. We were spending a lot of money doing written reminders,

but we weren't getting the bang for our buck. This led us to adopt an innovative technology-driven outbound call system to targeted members. We're into our third year, and we're still getting dramatic, but indirect, results from our outbound calls," Popiel says.

The company partners with Eliza Corporation, a Boston-based provider of speech recognition technology, on the preventive call program.

Horizon BCBSNJ staff collaborated with Eliza representatives to create scripts that the technology company turned into spiels by digitized voices.

The health plan uses its member data to compile lists of members who are appropriate for the services.

The reminder program is broad-based and goes out to the entire eligible population at targeted times during the year.

If an analysis of claims data shows that the members have not gotten the recommended screening examinations after a certain interval, the system calls them with another reminder.

"We are mindful of the fact that while these telephone calls are a third of the cost of a written reminder, we're making a lot of them. We want to make sure that each time we do call a member, the call produces the result we want," he says.

During the call, the system asks the member to answer a series of questions about why he or she hasn't gone for the screening exam.

For instance, the member can indicate if he or she was too busy or didn't think the services were important.

"We're not just sending reminders. We're collecting information about barriers to preventive care. The computer is collecting this information and putting it into a database, and we're able to do process improvement using the information," he says.

For instance, if the members indicate that their physicians have not recommended the preventive procedures, the health plan may develop an education program for its physician network.

When someone has not gotten a test, such as a mammogram, and indicates that they intend to do so, the system can do a warm transfer to a radiology scheduling line to help them schedule an appointment.

About 16% of people who are called have not gotten the test and want to be connected to a scheduling line so they can immediately make an appointment. Many ask for the number so they can call it at a later time, Popiel adds.

The health plan has begun using the interactive calls in its disease management programs and is exploring other applications of the technology.

"We know that we can collect information using a computer and voice technology, and given the early success with these programs, we are looking at new ways to improve patient care using this technology," Popiel says. ■

Physician engagement pays off for DM firm

Team inputs data for patient files

When QMed contracts with a health plan to manage its coronary artery disease, heart failure, or diabetes population, the Laurence Harbor, NJ, disease management firm does more than just rely on claims data to come up with a treatment plan for members identified for disease management.

The company also sends a team of specialists into individual physician offices to extract data from the patient files of members identified for the program, often coming up with clinical information and medical histories that aren't available from the insurance carrier. This gives the disease management company a more complete picture of the total patient and his or her health care needs.

"An employer group on average switches carriers every three years. The health plan's database may not have all the patient information that the doctor has in the patient chart. By accessing the chart, we can include information and patient history that occurred years ago," says **Robert Mosby**, vice president for corporate strategy and government affairs at QMed.

When a health plan contracts with QMed, the vendor uses its proprietary software program to perform a thorough analysis of claims to identify which patients should be in the program.

For instance, patients identified for the coronary disease program are those with a history of heart disease, those with potential coronary artery disease (such as those with a positive stress test or with a family history of the disease), and those at risk. At-risk members include males over 45 and females over 55 who have two or more risk factors such as family history, high cholesterol, hypertension, diabetes, or smoking.

The software also cross-references the patients'

primary care physicians and creates a list of each physician's patients.

"We then go to the physician with a description of the program and a listing of the patients who could be enrolled in the program. We ask them to sign off on the program and to reach out to their patients and help get them enrolled," Mosby says.

Getting the physicians to recommend the program is far more effective than having a company spokesman call a member, he adds.

"A doctor recommendation is a powerful way to get members enrolled in the program," he says.

After patients sign up for the program, the QMed team gets the permission of the patient and physician to include information from the patient's charts in the company's database, where it is combined with administrative claims data to create a complete picture of the patient's medical history.

A team of specialists visits each physician's office, extracts information from the patient charts, enters it into a laptop computer, and sends it by a secure data line to the company's database.

Using proprietary algorithms, QMed takes the data and generates a set of specific recommendations for each patient based on patient data and lab information in the chart and taking into account the age, race, and sex of the patient.

QMed then sends the physicians evidence-based recommendations specifically tailored for each of their individual patients, based on best practice guidelines and information from the patient chart.

"We give evidence-based best practice recommendations and update them regularly. We're giving the primary care physician a tool that represents the best recommendations from an expert system," Mosby says.

The database includes information from the health plan's pharmaceutical formulary, enabling the company to generate specific drug recommendations for that particular patient in accordance with the formulary of that patient's health plan.

"Our program reduces the variation of practice and the primary care level," Mosby says.

The company operates a call center staffed by nurse case managers who call the members at intervals determined by risk stratification. Members are assigned to an individual case manager in hopes that the two will develop a bond, Mosby says.

The nurses who make the calls are familiar with the physician's recommendations. They motivate the members to make lifestyle changes, take their prescribed medications as directed, and comply with other physician recommendations.

"Our model seeks to engage the patient and to educate the patient with primary emphasis on motivating them to comply with the medication and recommended lifestyle changes," Mosby says.

Compliance rates for members in the QMed disease management programs are about 2.5 times the national compliance rates, he says.

In one Medicare HMO population, total population costs dropped by 17.38% after one year of the QMed program. At the same time, heart attacks were reduced by 25.8%, 60% of hypertensive patients showed an improvement in blood pressure, ischemia decreased significantly in 58% of patients, catheterizations dropped by 11%, angioplasties were reduced 5.2%, bypasses were reduced by 3.68%, and hospital admission for angina fell by 23%. ■

URAC: Health plans still not compliant with HIPAA

Report identified barriers to compliance

With less than a year left before the HIPAA Security Rule goes into effect, a study by URAC has shown that the majority of health plans are not prepared.

"Many health care organizations have a long way to go to implement a health information security program that meets baseline regulatory and business requirements," says **Gary Carneal**, URAC president and chief executive officer.

He recommends that organizations immediately start the process, because most security risk management programs can take up to a year to implement fully.

Health organizations must develop a health information security program to comply with the HIPAA Security Rule by April 21, 2005. The rule requires that health care organizations develop a specific plan for protecting the integrity, confidentiality, and availability of electronic protected health information.

URAC, an independent, nonprofit health care quality organization, spent 18 months consulting hundreds of health care organizations through telephone interviews or through the URAC accreditation process.

The organization concluded that only a small percentage of these companies have implemented a comprehensive security management program that meets the HIPAA requirements.

URAC's report, "An Assessment of HIPAA Security Preparedness: Most Health Care Organizations Remain Noncompliant," lists four barriers to compliance and how to remedy them:

• **Incomplete or inappropriately scoped risk analysis efforts.** Health plans should conduct a thorough analysis to determine whether electronic patient data are at risk of compromise. The analysis should include a detailed identification of likely threats, vulnerability, and impacts to an organization's electronic patient data and the types of controls necessary to thwart them.

• **Inconsistent or poorly executed risk management strategies.** All of the organizations surveyed by URAC had serious issues with policy and procedure documentation, management, and implementation. The organizations should actively address the technical issues and employee practices that affect the security of electronic data.

• **Limited or faulty information system activity review.** The HIPAA regulations require an organization to provide an accurate history of system activity in the event of a security breach. Organizations should collect data on how their systems and employees are performing. They must establish policies and procedures relating to the frequency with which the data will be analyzed.

• **Ineffective security incident reporting and response.** Health care organizations must be able to detect when patient data have been compromised and have procedures in place to deal with the compromise.

URAC recommends that HIPAA efforts should be managed in the broader context of overall business risk. The goal is to create a security "due diligence" package that presents a single vision of business risk.

URAC offers HIPAA Privacy and Security Accreditation Programs, Security Audit services, publications, educational conferences, and workshops. For more information or to read the entire report, go to www.urac.org. ■

System helps therapists identify patients at risk

Clues often missed in interviews

A system to help identify patients who are at risk for suicide, chemical dependency, or premature treatment termination is a great adjunct to traditional psychiatric care, asserts **Daryl E. Quick**, PhD.

Quick's organization, Western Psychological and Counseling Services, uses the ALERT Predictive Modeling and Outcomes Management System from PacifiCare Behavioral Health.

The 90 therapists in the group use the ALERT system for patients who are enrolled in PacifiCare Behavioral Health's mental health and chemical dependency benefit programs, says Quick, president/chief executive officer of the Tigard, OR-based counseling service.

Using the ALERT system, Quick and the other practitioners in his office ask patients to fill out a 30-item questionnaire at regular intervals. The information goes into a PacifiCare Behavioral Health database that compares the patients' answers with physician-reported data.

During the interview process, therapists look for clues that indicate suicide risks, potential chemical dependency, or that the patient may be considering terminating treatment.

They ask questions such as: Are you gaining weight or losing weight? Are you drinking more than usual? Are you sleeping well? Do you feel stress?

"We look at a cluster of symptoms and use them to make a diagnosis," he says.

The system is helpful because it gives the therapist another way to identify whether patients are at risk and because the reports help them measure whether the patient is making progress, Quick says.

"Just looking at the answers to the questions can make the therapist aware of the overall level of distress right off the bat. We can look at the

COMING IN FUTURE MONTHS

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- How ISO 9001 certification can ensure organizational quality
- Case management for members receiving home health services

questionnaire and score it quickly, getting a better idea of the person's state of mind," Quick says.

Often, the feelings that patients describe in an interview are different from those the questionnaire elicits, he adds.

"People may have trouble saying they have considered suicide and it wouldn't present in an interview, but they give answers on the questionnaire that indicate they may be suicidal," Quick says.

After submitting the questionnaire to PacifiCare Behavioral Health, the therapist receives a case report showing the patient's score on the questionnaire, severity range, and critical items.

"This alerts us to a problem if we haven't already learned of it," he says.

The therapy group gets an outcomes report containing aggregate data as well as individual patient scores over time.

"This data allows us see real movement or lack thereof by patients. It's a useful tool to let us know when we are making progress with our clients. It's a great way to create a psychological outcome that has real meaning," he says.

Researchers at PacifiCare Behavioral Health developed the ALERT system following a three-year study involving 43,000 patients and 3,500 mental health providers that showed clinicians miss early warning signs of suicides 57% of the time, compared with information in reports filed by patients themselves.

Outcomes studies by the company show that ALERT was effective in reducing the number of substance abuse cases typically missed by practitioners by 17% and increasing practitioner detection of suicide risk by 35%. ■

CE questions

5. The eight agencies in Chicago's Westside Collaborative Care coalition came up with a standardized assessment used to assess uninsured patients who need services. How many questions are in the assessment?
A. 10
B. 45
C. 22
D. 8

6. BlueCross and BlueShield of Oklahoma assigns cases to case managers based on acuity. What is the average number of cases each individual manages?
A. 40 to 60
B. 15 to 25
C. 75 to 100
D. 30 to 40

7. In 2001, what percentage of patients managed by RMS Disease Management Services achieved or exceeded dialysis targets?
A. 80%
B. 93%
C. 75%
D. 98%

8. Horizon Blue Cross Blue Shield of New Jersey has found that automated telephone calls reminding members to get preventive health care services are more effective than mailed reminders and are about one-third of the cost.
A. True
B. False

Answers: 5. C; 6. A; 7. A; 8. A.

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. ■