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Three-pronged approach improves care for Medicaid members

Proactive case management replaced traditional UM services

Keystone Mercy Health Plan, Pennsylvania's largest Medicaid managed care plan, takes a proactive approach to preventing and managing illnesses, injuries, and utilization among its 285,000 members by providing targeted case management and outreach to members with chronic conditions.

Keystone Mercy, with headquarters in Philadelphia, provides coverage for 285,000 Medicaid recipients in five counties in southeastern Pennsylvania.

The health plan revamped its services to members a year ago, replacing its traditional utilization management model with a three-pronged plan that provides care management to its pediatric population, members with chronic conditions, and those who are at risk for major health care services.

"We realized that the traditional model of utilization management and short, episodic case management was not reaching all the Medicaid members we needed to reach and was a reactive model. We looked at our population and their needs and how we could be more proactive in serving them," says **Jane Israel**, RN, BSBA, CCM, CPHQ, vice president of clinical services for Keystone Mercy.

Before the reorganization, Keystone Mercy provided traditional health plan services — utilization management, prior authorization, and short-term case management — for members who needed post-discharge services such as infusion or home health services.

"We weren't looking at proactive management. We relied on the physician, hospital, or home health agency to trigger a referral to case management," Israel says.

Under the new model, the health plan identifies people who are likely to need care and provides case management and disease management services to help prevent them from needing intensive interventions, she notes.

It's too early for the health plan to have hard outcomes data, but a

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pilot project showed "compelling results that indicated it's much more cost-effective to manage members in this manner," Israel says.

Before developing the new member-centric model, the health plan analyzed all its claims data using a predictive modeling program to identify members who needed outreach services, based on the severity of their illness and other needs.

"We identified the types of diseases and conditions affecting our population and used that information to develop programs to meet the needs of our members," Israel adds.

The health plan uses many methods to reach the Medicaid population that qualifies for its case management programs, including telephone calls, mailed reminders, a newsletter, community outreach, and partnering with the members' primary care physicians.

If they don't reach members through telephone calls or mailings, the case managers work with the primary care physician to try to contact the member.

The case managers are required to attend continuing inservice education and training about the cultural issues and ethnic beliefs within the population that can influence members' willingness to obtain and comply with medical treatment.

The health plan's member outreach starts at birth with a pediatric case management program that focuses on early preventive screening and immunizations, normal growth and development, and safety issues within the home. For instance, providing preventive education to parents about common injuries to toddlers due to falls and poisoning is important, Israel notes.

"With a Medicaid population, it's important to make sure the parents to have a good understanding of their children's health care needs and to provide periodic reminders to improve compliance," she says.

When a pediatrician recommends additional services for a child, the case managers follow up to make sure the child receives the services. The health plan's claims database flags cases when additional services, such as surgery, adaptive equipment, or consultations with a specialist are recommended. If the child doesn't receive the recommended services within 90 days, the case manager follows up with the parents.

The case managers help parents find a provider within the network, assist with transportation issues, and identify any other barriers to getting care.

The health plan provides disease management for members with chronic disease and high-risk pregnancies through Health Management Corp. (HMC), a Richmond, VA-based national disease management vendor.

"The results of our population profile indicated that we had a large number of members who had certain chronic illnesses, such as asthma and diabetes, who could benefit from education and assistance in managing their diseases," Israel says.

"We identified other members with conditions

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like chronic obstructive pulmonary disease, congestive heart failure, and coronary artery disease who could become high utilizers unless they take steps to modify their lifestyle and manage their chronic illness," she adds.

Keystone Mercy concluded that it would be most cost-efficient to contract with a national vendor who had the telephone support system already in place rather than creating its own disease management programs for large populations.

The population-based disease management programs are augmented by locally developed disease management programs for members with rare, high-cost diseases, such as sickle-cell disease, hemophilia, and HIV/AIDS.

"These disease can be very expensive and they can be kept under control through close management," Israel reports.

For instance, the health plan's 60 members with hemophilia represent only a small percentage of its 285,000 members, but their care exceeds $10 million a year.

Members are identified through pharmacy data and referred to a case manager who works with them to help them better understand their disease and to help them take steps to keep the disease process under control. The health plan has created a pharmacy network that provides discount prices on the medication.

Members who have very high predictive scores for current and future illnesses are flagged for the company's care coordinator program. The case managers provide a combination of disease management education, social work services, and case management.

Unlike the members who are identified for the disease management programs, members in the care coordination program have intensive needs. They may need coordination of services among multiple providers. Many are homebound or homeless, and most have problems with transportation.

These members have three or more chronic diseases, are on 10 or more medications, and have an inpatient admission rate five times that of the health plan's average.

"This population presents a challenge that is not effectively met by providing traditional disease management education," Israel says.

The members are assigned to a care coordinator, a nurse case manager who conducts outreach by mail and by telephone.

She conducts a complete health risk assessment and defines the members' urgent needs, helping them overcome barriers to care, such as going to routine scheduled appointments with their primary care physician, obtaining prescribed medication, lack of transportation, and obtaining needed medical equipment. The case manager works with the member's primary care physician to develop a plan of care.

A case management technician, a trained paraprofessional who calls to collect outcome data, assists the care coordinators.

For instance, if a member has diabetes and heart disease, the case management technician will call at regular intervals and collect blood sugar and blood pressure data, alerting the case manager when the indicators are out of the recommended range.

"The case management technicians have a good understanding of medical terms, and many have experience as medical assistants in a physician office. We look at them as being case management extenders who help us maximize the number of members we can touch," Israel says. ■

Care Calls helps members manage chronic diseases

Program includes materials, self-monitoring tools

Using a combination of telephone calls from certified case managers, written materials, self-monitoring tools, and reminder messages to physicians, Univera Healthcare is helping members learn to monitor their chronic diseases.

The goal of the program is to support members with chronic diseases by telephone rather than providing classes or group sessions for members with diabetes, asthma, depression, and heart disease, says **Jay Pomerantz**, MD, vice president and chief medical officer for the Buffalo, NY-based health care plan.

Care Calls is provided as a basic level of service to all members who choose to participate.

"Since August 2001, our Care Calls program in Western New York has educated and supported more than 1,775 members with chronic diseases. It's an excellent, hassle-free alternative to classes or group sessions," Pomerantz reports.

The program offers telephone support for members with diabetes, asthma, depression, and heart disease.

The purpose of the program is to get the members to learn to manage and monitor

their own health.

The health plan sends incentives to members in the program, including scales for heart failure patients, peak flow monitors for members with asthma, a choice of glucometers for participants in the diabetes program, and medication containers for those in the depression management program.

The nurses who make the Care Calls all are registered nurses who have been certified as case managers. They have undergone extensive training on each of the four disease states and are backed up by the plan's medical directors, who are available for consultation, adds **Peggy Davis**, regional director for medical benefits management, utilization management, and case management.

The nurses are cross-trained to work with members regardless of their illness.

Program promotes job satisfaction

The program has generated a lot of job satisfaction, Davis notes. "We have a very stable team. There's been no turnover since the inception of the program. The nurses have a lot of professional pride. They've worked together and seen the program grow."

When a member is identified for the program, he or she is assigned to whichever nurse is free. The nurses work with the same panel of members during the time they are in the program. The exception is that when a nurse is on vacation, her colleagues will handle her members.

"We felt that it was beneficial to develop a patient-nurse rapport," Pomerantz says.

The health plan developed a standard curriculum for each disease state with the help of its physician advisory committees.

For instance, local cardiologists helped develop the heart failure program.

"We have standard topics that are covered during the education portion. In addition, we take a look at evidence-based clinical guidelines at least yearly to make sure the education we provide remains current," Davis says.

The curriculum for each disease is divided into five modules, which the case managers cover at the pace of the member.

Members receive at least five telephone calls and as many as 10, depending on how well they were able to absorb the information, understand their disease, and start managing their own health care.

"If they continue to struggle with self management, the nurses will work with them longer," Davis says.

The health plan started its disease management efforts with a telephone program for members with congestive heart failure.

"We were looking at informed decision making and evidence-based management for the patients and how to use ongoing telephonic contact to assure adherence," Davis says.

The care managers supported the members in managing their congestive heart failure, encouraging them to watch their diet, exercise, take medications as prescribed, and weigh themselves daily.

The health plan has gradually expanded the Care Calls program to include members with diabetes, asthma, depression, coronary artery disease, and smoking cessation.

The health plan's behavioral health staff trained the nurses on how to identify when a member is ready to change.

"People can circle up and down in readiness for change. We gave the nurses dedicated training on the Prochaska model and how to identify at which stage the member is," Davis says.

Patients are identified by claims activities, referrals from physicians, self-referrals, and with a health risk assessment tool for the plan's Medicare patients.

Univera Healthcare's on-site nurses, who perform utilization management and concurrent review in major hospitals, frequently refer members to the program when they encounter someone with a chronic disease either in the hospital or emergency departments.

"The on-site nurses visit all of the Univera Healthcare members in the hospital and discuss programs and services, such as Care Calls, that are available to them. If the members are not in a hospital where our nurses are located, we tell them about the Care Calls program when we make post-discharge calls to make sure the member understands the discharge instructions and makes a follow-up appointment with their physician," Davis says.

Once the members are identified, the Care Calls nurses try to reach them by telephone. They call three times on different days and at different times of day. If they are unable to reach the member, they send him or her an introductory letter, inviting the member to join the program.

The Care Calls program is an opt-in program in which many members choose to participate.

"When we get into coaching and lifestyle modifications, some people no longer want to participate. For instance, if they aren't ready to stop smoking, they may exit from the program," Davis says.

"We have a high participation rate at least partly because the program is nonthreatening. The nurses are there to be advisory and helpful, rather than being critical and judgmental," says Pomerantz.

Follow-up is driven by the severity of the members' conditions, how stable or unstable they are, and where they are in treatment. If a member experiences an exacerbation, the nurses will call more frequently.

For instance, when a member is newly diagnosed with depression and just starting on medication, the nurses will call him at least weekly, working on medication compliance and supporting him during the early days of his treatment.

"We want to provide motivation and reinforcement in the time when they haven't yet seen the benefits of the medication," Davis says.

Educating members

A congestive heart failure patient who is just out of the hospital will receive frequent calls as well, while a member whose condition is stable and who is able to self-manage may get a phone call as infrequently as every three months.

The nurses educate all the members they work with about Univera Healthcare's Member Rewards discount program, which offers discounts on programs and services that range from health club memberships to Lasik eye procedures.

The health plan's disease management program includes working with the members' primary care physicians and specialists to make sure the members receive recommended tests and screenings and assure the continuation of long-term interventions.

For instance, the physicians receive patient management reminders at least quarterly. In many cases, the physicians' office management system interfaces with Univera Healthcare's computer system, allowing the health plan to send patient reminders overnight before the patient's appointment, prompting the physician on what kind of tests or examinations the member needs.

"The physicians love it. It's voluntary, and every office we've offered it to has elected to enroll. It saves staff time going to chart to find out when a patient had a colonoscopy or an eye examination," Pomerantz says.

The health plan sends the physicians reminders of the medications the patient takes, any emergency department visits, smoking cessation classes, when the last labs were done, and what the lab values were. ■

Cultural competency program improves services

Publicly funded population is from many cultures

An innovative cultural competency program has helped Molina Healthcare serve a highly diverse membership covered under Medicaid and other government-sponsored health care programs.

Molina, with headquarters in Long Beach, CA, focuses primarily on the Medicaid and low-income population, using case management, member outreach, and low-literacy programs to reach members in multicultural populations.

About 80% of the health plan's members in California are from diverse ethnic groups.

In addition to traditional barriers to health care among the publicly insured populations, such as poor literacy and transportation issues, many of Molina's members face cultural barriers as well.

The company has established a cultural and linguistics services program to help its employees understand how patients' cultural background affect their approach to health care.

"In California, we have people coming from all over the world who may never have had any experience with an organized health care system. One very important intervention is explaining how the health benefits work, and to do so means our care managers must understand the members' cultural background and ways that it can create barriers to receiving health care services," says **Anne LaSette**, director of quality improvement for Molina Healthcare.

For instance, in many Latin American countries, people can walk into a pharmacy and get care and treatment. An herbalist in their country of origin routinely treated other Molina members.

"They don't understand our health care system. That is something we have to explain very carefully. For instance, Sacramento is in one of the most diverse counties in the country. Our members speak Russian, Hmong, Vietnamese, Chinese, Spanish, and English," LaSette reports.

In Los Angeles County, most of the Medicaid members are Hispanic or Vietnamese. In San Francisco, Chinese is the dominant population.

The company's web site is in six languages — English, Spanish, Chinese, Hmong, Vietnamese, and Russian, representing the majority of the populations the company serves.

Every person who works for Molina goes through a comprehensive six-hour cultural training program to learn about the populations the health plan serves and become more adept at dealing with cultural differences.

Margie Akin, PhD, a cultural anthropologist, oversees the cultural competency program, ensuring that all of Molina's initiatives, from materials for new members to telephone protocols are developed keeping the cultures of members in mind.

Many initiatives ensured proper translation

The health plans have developed many initiatives to make sure that materials are accurately translated into the languages that members speak and that they are culturally sensitive, adds **Marian Ryan**, RRT, MHP, CES, corporate director of health education and disease management.

The health plan has created an internal cultural and linguistics advisory commission made up of key people from every department who come from a variety of backgrounds and who identify and discuss cultural issues that may be barriers to health care and identify strategies to help resolve them.

The health plan brings program designs and materials to a cultural advisory committee made up of members of the community, which meets every two months.

"We ask the experts to advise us on any problems they see with the materials while they are in the early stages of development and to suggest different approaches for various populations," Ryan says.

It's particularly important for the health plan to have clear communications to ensure that members with chronic conditions such as asthma, diabetes, and congestive heart failure understand the importance of compliance, LaSette points out.

Member services representatives call newly diagnosed members using a script approved by the California Department of Health Services.

The health plan has created language-specific videos for members with diabetes and asthma in its disease management programs.

"Some of our members don't read, even in their native language. They may not have finished but a few years of schooling and they couldn't even read even our materials that are translated at the fifth-grade level," LaSette says.

The company translates its materials into five threshold languages and uses only certified translators when talking with members in person or on the telephone.

"In doctor's offices, we identify what languages are spoken and steer our members to an office with someone who speaks their language. If a member hasn't selected a doctor, we try to do a language preference match whenever possible," Ryan says.

The health plan has a contract with a translation service and gives members a laminated card with "I need help with translation" in English and five other languages, along with a telephone number for the translation service.

"If a member is at a doctor's office or a pharmacist office and is having trouble communicating, the health care provider can call the language line for a translator, LaSette says. The health plan has case management programs for diabetes, asthma, and high-risk pregnancy, identifying members through pharmacy claims and encounter data.

They often come up with innovative programs to reach members with the disease.

For instance, when it launched a pediatric asthma program for children with asthma, the health plan set up classes for families, providing transportation, day care, and grocery coupons to members who participate.

"As a practicing respiratory therapist, I believe that personal education is best, but we couldn't get the families to go to class," Ryan says.

The company decided to create a telephone-based asthma education program instead and sent families a learning kit that includes a workbook and a video produced in-house. The video and workbook are in English and Spanish.

Families receive peak flow meters and other materials through the mail. Molina's outreach staff made outbound calls to the families to help them understand how to use them.

Plan provides follow-up with members

The health plan follows up with members and sends reports of their interventions to the primary care physician through chart notes.

The health plan comes up with innovative ways to ensure that members, especially children, get the services they need, LaSette says.

For instance, in many of the plan's families, the grandmother is taking care of the kids and never got an immunization when she was growing up

and doesn't see the need for her grandchildren to be immunized.

In California, state law has made it virtually mandatory for children to get immunizations when they enter school.

"Improving immunization rates has been a longtime focus of our company. It's on the front burner and is everyone's objective," LaSette says.

Each member who enrolls in the health plan receives a welcome call during which the nurse explains his or her benefits, discusses the importance of preventive health care, and schedules an initial health assessment with a primary care physician.

Members who see a physician for an initial health assessment receive a gift card from a local department store.

"We anticipate that the doctor will get them up to date with their shots. If they send in a card that shows they're up to date with their immunization and have had a health assessment, we send them the gift card," LaSette says.

Added perks for physicians

Physicians also receive additional payment for immunizations, in addition to their capitated reimbursement.

The health plan maintains an immunization registry using information from the county government, the school system, and other health plans.

"We keep a close check on that and send out postcard reminders when immunizations are due," LaSette reports.

Using Quality Spectrum, a quality reporting software from Catalyst Technologies in Snellville, GA, the health plan mines its data twice a year, identifying every child who does not have a documented claim for immunizations or other preventive services.

The plan contacts the member's primary care physician, reminding him or her to make sure the member receives the recommended care.

The health plan sends reminders of immunizations that are due to the families of all children age 2 and younger. Older members receive annual birthday cards along with information on the appropriate preventive health measures, including immunization, recommended for their age group.

A quarterly newsletter for all members emphasizes the importance of immunization. A newsletter for members ages 12 to 21 includes information on preventive care measures for older children. ■

Studies show wellness cuts disability costs

It's just another benefit of health promotion

It has been a long, hard struggle for wellness proponents to prove the ultimate value of health promotion programming in terms of employee health and well-being. In the early days of wellness — say, the 1980s — even the companies that had such programs tended to look upon them as benefits that were *nice to have,* but nothing a company would *need to have*. As the '90s unfolded, more evidence came forward demonstrating that wellness did, in fact, contribute to a reduction in health insurance costs/claims, helping to move wellness into the *need to have* category for a growing number of companies.

Now, it seems, there is a growing body of evidence that health promotion also can contribute to a reduction in *disability* costs, according to **Don R. Powell**, PhD, president and CEO of the Farmington Hills, MI-based American Institute for Preventive Medicine, a wellness consulting firm. "First of all, when you look at disability and loss control, programs that provide a safe and healthy work environment for employees can reduce the number, severity, and cost of workplace injuries and illnesses," he reports. "Work site wellness is *designed* to help employees change their lifestyle to improve health and reduce costs."

Overlap seen

Powell adds that improved employee health and cost reductions "overlap in major ways," adding, "clearly we've now been able to see a relationship not only to health care costs, but to issues related to disability management."

He points to one study conducted by Xerox between 1996 and 1999, involving 3,338 employees. "They looked at the association between health risks and workers' comp costs and lost injury days," he notes. "They found that 7.9% of all employees incurred workers' comp claims, and among those, 26% had lost injury days. Then, they looked at HRA [health risk appraisal] participants only — only 5.6% had workers' comp claims vs. 8.9% of non-HRA participants."[1]

The natural assumption is, Powell adds, that if employees are made aware of a health risk by taking an HRA, they will do something about it.

Additional findings seem to bear him out; the Xerox study found among that among HRA participants, 4.9% of those who had low risks had workers' comp claims; of those with median risk, 5.5% had claims; high-risk had 8.2%.[1] "This clearly shows a link between healthy lifestyle and decreased workers' comp claims," Powell asserts. "And if you can improve [the risk levels of] those medium- and high-risk people, you will further improve your claims as well."

Fewer disability days

Another study Powell cites examined health promotion and disability days at a manufacturing company. "This was conducted over a five-year period with a working population of 4,189, of which 2,596 participated," he reports. "They found a savings of $623,000 per year, or a return on investment of 2.3-to-1 in terms of the decrease in disability absence days [days of missed work factoring in participation in a wellness program]."[2]

A third study, by Hughes Electronics, examined wellness and short-term disability. "Participants in the wellness program had a significant percentage reduction in short-term disability," says Powell.

While conceding the benefit is tough to define, he says what is being shown in these studies is "where what we saw in the early days of wellness were healthier employees, we now also have decreased workers' comp claims."

The benefits, Powell adds, go above and beyond just health care cost reduction, impacting reduced absenteeism — "Whether for colds and flu or decreased workers' comp claims."

Explaining the connection

Why does wellness impact workers' comp claims as well as health care costs? "Wellness helps employees lead healthier lifestyles; they quit smoking, lose weight, lower their blood pressure, and in general become more physically fit," Powell explains. "Those employees who are more fit and not overweight will avoid back injuries and musculoskeletal disorders, as well as major disabilities like heart attacks," he adds.

This, then, becomes another reason for companies to institute or expand their wellness programs, says Powell, and also explains why wellness is now being integrated into other areas of company management — benefits, occ-health, and even the work/life area. "Wellness now transcends more than one corporate department," he notes. "If a company can justify footing the bill for a wellness program that can decrease costs in more than one area of the company, that's all the more rationale to go ahead with it," he concludes.

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CIGNA study supports integrated benefits

Disability, health care work in tandem

A new study by Philadelphia-based CIGNA confirms what a number of health care professionals have been asserting: the integration of disability and health care programs can help return disabled employees to work more quickly, or even prevent absences, and also can lower total benefit costs. As a result, CIGNA will institute discounts of between 3% and 7% for clients who purchase short-term disability (STD) and long-term disability (LTD) coverages in conjunction with CIGNA medical coverage.

The study, called "The Disability and Healthcare Connection . . . How Strong Is the Link?" examined STD claims data from 60,000 employees in 156 companies and compared results of those covered by both CIGNA STD and medical care with those covered by CIGNA STD and a different medical insurance carrier. Among the key findings:

The duration of short-term disability, and how quickly the employee returns to work full time, is better for those with an integrated disability and health care program.

While chronic illnesses such as heart disease, diabetes, and low back pain represent 26% of the medical episodes that lead to a disability, they account for 56% of STD-related medical costs.

A full 45% of the expense of treating depression and other mental health conditions stem from individuals who seek treatment for disabilities other than mental health, such as low back pain or heart disease.

Both direct and indirect STD claim-related and medical costs often continue after return to work.

Most of the top drivers of short-term disability costs match the top drivers of medical costs.

A closer look at the numbers indicated that for a hypothetical employer with 3,000 employees, integrated coverage results in savings of between $100,000 and $200,000 in direct disability costs, and up to $500,000 in indirect costs (lost productivity, costs of hiring and training temporary replacement workers).

This is the first time CIGNA has done a study like this, says **Jay Menario**, CLU, senior vice president CIGNA group insurance marketing and strategy, who noted the study period was 2001-2003.

"We are one of the few providers who offer both [STD and medical coverage] under one umbrella, and we finally said, if our intuition tells us this improves outcomes and saves money, let's validate it," he explains, adding that "when we are dealing with customers and consultants, they often ask whether the benefits of integrated coverage can be validated."

The move to integrated coverage is "more employer-driven," Menario observes. "They want ways to save dollars in benefit plans and where there are synergies and overlaps and redundancies. With medical costs rising, they like to do what they can save to money."

Passing along the savings, he adds, is a win-win. "For the most part, employers want quality coverage — they want to take care of employee wellness, but they want to find efficiencies and pay less — and rightfully so," he says. "If we can help them save real dollars, it helps them and it helps us."

Implications of study

What are the implications of these findings for occupational health professionals? There are several important messages, says Menario.

"First, there should be proactive outreach," he advises. "We can get notification from the medical area even before a disability event has occurred." For example, Menario says, if an employee is admitted to the hospital, it often will be clear that this will be a disability case. "We can begin the process before they even file; reach out to them and say, 'Here's a claim form,'" he notes. "Early notification helps us either keep employees at work, or get them back to work sooner."

Since the study shows that chronic illnesses account for more than half of all STD-related medical costs, Menario says, this indicates how important it is to have good disease management programs in place to address those chronic conditions. "If the occ-health nurse or physician can focus on those conditions and do good disease management, you will not only see benefits to disability costs, but also to medical costs," he asserts.

A third key message is the need to take a holistic approach to claims. "Of all the people who had some type of psychological or mental nervous condition, 45% of the time it was the result of some other condition," notes Menario. "For example, chronic back pain can yield depression. If you treat a mental health disability as only a psych claim, you may miss the root cause of the condition."

It's also important, he says, to recognize that even when employees are back at work, they may not be ready to perform at a 100% level.

"You might want to think of those employees almost as the walking wounded," Menario says. "It's great they're back at work, but they may not be as productive as they could be. For example, they may have a lingering problem; when you can be cognizant of that, you can see if there's anything you can do to make the work environment more productive and comfortable."

Without that approach, he says, the employees' productivity and perhaps even their health may suffer. Menario notes that an earlier CIGNA study showed that some returning workers who experience high levels of anxiety face the chance of greater stress levels, and perhaps even a recurrence of injury.

A new paradigm

The combined import of the study's findings leads logically to what CIGNA calls a new paradigm for looking at benefits.

Under the old paradigm, a disability event was considered to start when an employee filed a disability claim, and ended when he returned to work. Based on the study's findings, however, when employees have a disability and are out of work, this also may be a leading indicator of their medical costs.

For example, the study found, on average, the total direct disability and medical cost of a short-term disability is $13,094. Of this, $2,444 is associated with STD benefits and $10,649 with medical benefits.

"In a way, this is a bit connected to the statistics that showed chronic conditions represent 26% of medical episodes but account for 52% of

medical costs," Menario explains. "In the past, employers have always looked at disability and medical costs as unrelated. This says that if you *really* look at the real costs of STDs, you can't just look at the premium; you have to look at how you use medical services."

Which leads back to CIGNA discounting coverage. "We saw two important statistics — the average duration of STD claims was reduced by 12% [with integrated coverage] and the number of people we were able get back to work full time prior to expiration of STD benefits increased by 6%," Menario notes. "That's where we see savings in terms of benefit dollars and reserves. If we didn't do the discounts up front, our customers would see the benefits over time; but we were willing to do the discount and offer the right rate at the right time — we trust the data, and we trust that the employers' interests are aligned with ours."

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Advance planning eases care for aging

Seniors, close relatives should prepare for aging

Planning is something Americans do on a regular basis. They plan their vacations. They plan for the birth of a new baby. They plan for retirement. And they even plan for death. Yet few plan for the aging process. "It is good for people to start to think ahead," says **Marilyn Rantz**, PhD, RN, director of the Center of Excellence in Aging and a professor at the school of nursing at the University of Missouri in Columbia.

Families need to consider the various scenarios that could take place as people age, such as not being able to drive or maintain a house. Then they should research the services and options available within their community, and work with close family members to develop a plan.

Rantz has talked to seniors and family members who volunteered at nursing homes, assisted living, or senior centers to help them become familiar with the services available to seniors in their community. "That saved so much stress in those families who were proactive and took the time to understand what services there were in their community," she notes.

Michael Doran, CSW, coordinator of Caregiver Services at Health Outreach, New York Presbyterian Hospital in New York City, often meets caregivers who are overwhelmed with the responsibilities of caring for an elderly loved one while trying to meet work and family obligations. "Quite often when people present for help, they feel things are out of control," he says.

To help families prepare for the care of aging relatives, patient education coordinators can provide information on what types of resources might be needed by seniors and their family members, how to determine when it is time to make use of such services, and how to find services that meet budget constraints and family requirements.

A list of community outreach centers would be very useful to families looking for help with the care of aging family members, says **Collette Schelmety**, RN, assistant nurse manager on the Acute Care for the Elderly (ACE) unit at New York Presbyterian-Cornell Hospital in New York City. These centers have access to the resources that families may eventually need for an aging relative, she says. For example, some have social workers who can help explain which services Medicare might cover, or they might offer home safety evaluations.

Local, state, and national agencies provide resources for older adults, says **Jennifer S. Browning**, MS, RN, CS, gerontology clinical nurse specialist at The Ohio State University Medical Center in Columbus. Senior centers within communities also are an important resource. They often have classes for older adults as well as social activities and meals.

Associations and organizations are good resources for disease-specific information. For example, the local chapter of the Alzheimer's Association based in Chicago provides services for caregivers of elderly relatives diagnosed with this disease.

Preparing for potential problems

As relatives age, it is important for family members to foster their independence, but the family also should stay involved and supportive as needed, Browning explains. For example, social isolation could become a problem if an elderly person cannot drive or is not physically

able to get out much. "They need frequent contact, even if it is just a phone call," she says.

Relatives also can encourage visitors. Interaction with other people and the stimulation of talking about current events and things of interest is important, Browning explains.

Caregivers need to be aware of the mental and physical changes that take place as people age so they know when to intercede, Schelmety notes. For example, some forgetfulness is common as people age. Therefore, it would be wise to take steps to prevent potential problems by putting a list of emergency numbers next to the telephone.

It's also important for caregivers to encourage elderly relatives to participate in activities that stimulate their minds. "Seniors can improve their memory by continuing to be active in such recreational activities as Scrabble or cards," adds Schelmety.

Caregivers should note dementia signs

Caregivers should note that signs of dementia include consistent loss of memory that affects activities of daily living and a person's ability to participate in social events, and to take care of him or herself, Browning says. In this case, an elderly relative would need more assistance and may need to be moved to an assisted living facility. Older adults also are at risk of depression, which is underdiagnosed and undertreated, she explains. It is important for caregivers to know the signs of depression in the elderly.

"Older adults present differently. Their only complaint may be physical symptoms such as fatigue," Schelmety says. As people age, there is a decrease in strength and balance and bones become less dense, so they are more susceptible to fractures, she adds. Therefore, home modifications may be required to improve safety. For example, better lighting might be installed and throw rugs removed.

"One out of three persons age 65 and older fall each year, and fractures are the most serious consequences of the falls. Many of the injuries can be prevented," Schelmety explains. People can obtain environmental safety checklists to evaluate their homes.

Medications can cause confusion as well as falls. Caregivers should review all medications an elderly relative is taking and learn the side effects of each as well as the proper dosage and method of taking them. Medication containers need to be clearly marked for older adults, Schelmety notes.

Vaccinations are a must for older adults

Certain immunizations and screenings are required for good health as people age; therefore, it is a good idea for people age 65 and older to begin seeing a physician who specializes in geriatrics, she says. Older adults should be vaccinated against pneumococcal pneumonia and influenza because these illnesses are in the top 10 leading causes of death for this age group.

While good health practices are vital at any age, there are many things the elderly can do to improve the aging process. For example, to increase strength, flexibility, and balance, they need to make exercise a part of their daily routine. Good nutrition and hydration is important as well, Schelmety explains. Communication between the aging adult and his or her caregiver is very important as long as interaction is possible. Good health practices, living situations, and care should be discussed and advance directives also should be set in place.

"Caregivers should find out what the older adult wants — they shouldn't assume anything. [Caregivers] need to communicate well with their loved one," Browning advises. ■

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CE questions

13. Which of the following does not represent one of the three prongs of Keystone Mercy Health Plan's targeted case management plan?
A. Pediatric population
B. Members with chronic conditions
C. Young adult population
D. Those at risk for major health care services

14. Buffalo, NY-based Univera Healthcare started its disease management efforts with a telephone program for members with what chronic condition?
A. Congestive heart failure
B. Diabetes
C. Asthma
D. Chronic obstructive pulmonary disease

15. Molina Healthcare in Long Beach, CA, uses which of the following languages on its web site?
A. Chinese
B. Hmong
C. Russian
D. All of the above

16. In a recent CIGNA survey, what percentage of medical episodes was represented by chronic illnesses?
A. 16%
B. 26%
C. 36%
D. 21%

Answers: 13. C; 14. A; 15. D; 16. B.

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. ■

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