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Medicare disease management program reduces amputations and spending

Face-to-face sessions are a cornerstone of program's success

An intensive face-to-face care management program for severely ill Medicare patients with advanced congestive heart failure and/or complex diabetes has paid off for XLHealth, a Baltimore-based disease management firm. The company has reduced spending by as much as 26% after 24 months of intervention for private HMO patients and has reduced lower limb amputations by more than 60%.

The program provides face-to-face care management sessions with patients and person-to-person pharmaceutical consultations when needed. In addition, the nurse care managers meet with physicians and their clinical staffs to discuss the patient's care plan.

"When the company was created, there were some disease management programs out there, and all used telephonic call center models. We felt that face-to-face contact with a nurse care manager and perhaps a pharmacist, in some cases, would be more effective for the Medicare patients who are at risk for increased health care needs and higher health care costs," says **Paul Serini**, executive vice president of XLHealth.

XLHealth was awarded the Disease Management Association of America's Recognizing Excellence Award for the Best Disease Management Program: Medicare. In addition, the company has been chosen by the Centers for Medicare & Medicaid Services (CMS) to conduct a three-year demonstration project for 10,000 Texas fee-for-service Medicare patients with advanced congestive heart failure and/or complex diabetes with a cardiac inpatient event and complications in the lower extremities.

The company predicts that the 10,000 patients in the program will see in aggregate a 50% reduction in amputations and other serious diabetes foot complications and a 50% decline in heart failure events. Patients enrolled in the program represent the sickest 4% to 5% of the Medicare population, Serini adds.

"Medicare fee-for-service patients with chronic illnesses are different from the type of patients who enroll in a Medicare health plan. They're not financially motivated, are slower to make decisions, and rely a lot

on the advice of family members and friends," he says.

The patients picked for the program are those who are at risk for consuming the greatest amount of health care resources.

"Most are socially isolated and clinically depressed with little social support. They don't want to bother the doctor. They can't drive to the podiatrist, and they don't want to call a taxi because it costs too much," he says.

Serini credits the face-to-face interventions for the dramatic reduction in amputations and health care costs.

For instance, many of these patients in Medicare programs have foot ulcers that they treat with over-the-counter medication, waiting until it becomes so severe that sepsis has set in or the patient is facing an amputation.

"We have found that when we call the patients before a home visit, about half of those who have ulcerated wounds say that their feet are fine. If they have neuropathy, they can't feel their feet. Many are obese and can't see their feet. They may live alone and not know they have problems or they may not know it's serious," he says.

Home assessment helps identify any problems that the patient has before they exacerbate into a costly health care experience, he says.

"Our medical experts tell us that almost 95% of amputations are avoidable from a clinical perspective if we intervene with the patient early enough," he says.

When XLHealth starts a program, the company examines the entire patient population and uses administrative, pharmacy, and laboratory data to stratify the population into five levels.

The nurse care managers call each patient and conduct a 15-20 minute telephone assessment. Depending on patients' level of severity, the nurse care manager asks if they would be willing to participate in a 45-minute face-to-face assessment.

The assessment may be conducted at the patient's home, at a special area set aside for XLHealth at a local pharmacy, at a physician's office, a senior citizens center, or another location that is comfortable for the patient.

During the assessment, the nurse care manager collects clinical data, checking diabetic patients for neuropathy and hot spots, conducts a depression screening, reviews all the patient's medications, and in some cases collects blood samples. "Based on 500 or more data points that we collect, the patient is restratified and the information is used to create a patient care plan that supports the physician's plan," Serini says.

The comprehensive care plan, created by XLHealth's proprietary computer software system, was developed with input from a medical advisory panel of cardiologists and endocrinologists who reviewed the proposed care plans.

When the initial care plan is developed, the nurse care manager goes to the physician office and meets with the physician and clinical staff to walk them through the report, ensuring that the plan supports the physician's efforts and telling

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them about frequency and content of follow-up reports.

"The packages that are given to the physicians were developed over a period of four years by asking physician groups what information they want and what they want the reports to look like. They are very physician-friendly and helpful," Serini says, adding that the disease management company gets a 96% approval rating among physicians.

The patient also gets a copy of the care plan and a follow-up telephone call from the care manager.

Recommendations in the care plan are flagged in the company's computer system until they are followed.

For instance, if a patient has a history of hypertension and is not taking an ACE inhibitor, the physician receives a report suggesting that an ACE inhibitor might be recommended for the patient, and the nurse care manager follows up with the patient, reminding him or her to speak to the physician about the drug.

"These two tasks are scheduled by the system, and they remain on the schedule until they are completed," he says.

Patients at the highest risk categories receive the most interventions. There is no set number of interventions per patient. Instead, they are event-driven.

For instance, the nurse care manager may suggest that a patient with foot problems go to a podiatrist and may arrange for transportation if needed. Two weeks after the podiatrist visit, the nurse care manager visits the patient to review what happened during the visit and to make sure the patient truly understands home foot care and foot issues.

"We are happy to pay for the follow-up because amputation can affect a patient negatively and it is expensive and it is always effective to have the care manager reinforce what the doctor told the patient," Serini says.

In another case, if a patient is on multiple medications and demonstrates a low level of understanding of why he or she is taking them, the patient is referred to a local pharmacist, who works with XLHealth. The pharmacist spends about an hour with the patient, doing a comprehensive medication review and educating the patient on what each drug does and why it is important to take it as prescribed.

The pharmacist has access to the complete clinical records and in some cases may discuss the patient's prescriptions with the physicians.

The pharmacist intervention has helped alleviate poly-pharmaceutical issues with many of the patients, he says.

"A lot of these patients are medically homeless, and their care is provided by a cardiologist, an endocrinologist, an internist, a hospitalist, and an emergency department physician. A patient may have a tremendous number of prescriptions. Working with the pharmacist, we routinely are able to stabilize the patient's medication by cutting out duplicates or medications that are incompatible," he says.

Most CMs work out of their homes

The program in each community is staffed by several levels of nurses: a program manager who is in charge of a group of nurses in a metropolitan area; six to 10 nurse case managers; a panel of per diem nurses who work for local home care agencies and are called on to manage various patient demands; nurse coaches who work with patients by telephone; and inpatient nurses who go to local hospitals and oversee the care of patients in the hospital who are not being managed by a health plan case manager.

"If a health plan has a robust case management program, the need is limited, but Medicare fee-for-service patients often don't have a case manager working with them except for the hospital case manager," he says.

When the program begins in a community, the nursing program manager meets with the large medical practices to describe what will happen.

Most of the nurse care managers work out of their home. They begin the day by logging onto XLHealth's web-based system and retrieving their work plan for the day, then prioritizing the patient visits. They go to the central office for staffing meetings and educational sessions.

Many of the company's call center nurses also work in their homes.

"This gives us great flexibility to be able to ramp up and ramp down when we need to," Serini says.

The first patients for the Medicare Disease Management Demonstration project were enrolled in April, with clinical interventions starting in June. About 8,000 of the 10,000 enrollees have received home assessments.

In addition to the Medicare Disease Management Demonstration project, the firm has collaborated with physicians and their Medicare HMO patients enrolled with major health plans.

Serini emphasized that the program is most effective for patients who are in a Medicare risk plan and might not be effective for the general population.

"Our program was designed for people who are seriously ill and are in a Medicare risk plan. It works extraordinarily well for this population, but it would not be a good program for a commercial health plan. A 45-year-old working diabetic has a very different profile," he says.

The company provides person-to-person interactions for between 30% and 90% of its enrollees, depending on the severity of the conditions of the particular population. The interventions are supplemented with telephone calls and packets of educational materials.

"We generally see about 70% of our Medicare patient population face-to-face. In a commercial program, if we are managing all the patients with diabetes or heart failure, many would not need face-to-face interventions," he says. ■

Program offers preventive health, chronic care

Quality indicators, patient satisfaction are tracked

As part of its efforts to promote preventive care and appropriate management of chronic diseases, Blue Cross and Blue Shield of Florida has begun the Recognizing Physician Excellence (RPE) program, which will reward physicians based on several criteria, including patient satisfaction, clinical quality and efficiency, and administrative efficiency.

The program is designed to complement Blue Cross and Blue Shield of Florida's disease management and case management programs, says **Robert S. Mirsky**, MD, regional medical director for the Jacksonville-based insurer.

"The case managers and disease managers have been providing the majority of support for members through our Personal Care Management and Chronic Disease Management programs. The RPE program encourages physicians to join in our effort to ensure that patients who need it get control of their chronic diseases and to ensure that patients get the preventative care they need. These are two very important areas that work together to create a system that results in optimum outcomes for patients," he says.

The company is collecting data on clinical quality indicators, patient satisfaction scores, clinical efficiency, and administrative efficiency indicators and will use that to compare physicians to their peers. The program takes the physician scores in all categories and compares them to each other, calculating the bonus payments based on how the physician meets the benchmarks. The bonuses will be paid on an annual basis, beginning in July.

The company contracts with Health Benchmarks Inc. of Woodland Hills, CA, to monitor physician performance.

"We developed a balanced score approach and included various areas where recognizing and rewarding physicians would make a difference in the way they serve their patients," he says.

Physicians eligible for the program are primary care physicians, including those practicing internal medicine, pediatrics, family practices, general practices, obstetrics, and gynecology.

They must participate in the company's Network Blue high-performing network and have a high volume of patients. Enrollment is voluntary.

The physician scorecards are developed using administrative data, claims data, and the results of patient satisfaction surveys.

"We take a member-centric approach. If any physician orders the testing or the care that we are tracking, all the physicians who treat that patient get credit for it because if the patient gets the care they need, it means the system is working," Mirsky says.

For instance, if a patient is seeing an internist and a gynecologist, both get credit if she gets a Pap smear or mammogram.

"It may be because of the way the group is orchestrated, or the way they refer patients in their community. We just want to make sure that the physicians have a system that results in the patients getting what they need," Mirsky explains.

The quality indicators the health plan is tracking include preventive measures such as mammograms and Pap smears and cholesterol management in the prevention of heart disease, and chronic disease management indicators for patients with diabetes and asthma.

For instance, the program tracks whether diabetics had a hemoglobin A_{1C} test and a retinal eye exam; asthma patients are on daily long-term medication; and patients are refilling their lipid-lowering medications.

"As the program evolves, we will increase the indicators and study the results of the laboratory

tests to determine if the members received the care they needed to reach their goals," Mirsky adds.

When patients leave the offices of participating physicians, they receive a bilingual postcard directing them to complete a 19-question survey about their health care experience either on the Internet or over the telephone. Members who participate are eligible for a drawing for rewards.

"We ask them about their perception of access to care, the quality of the care they received, and the overall care experience," he says.

The program also measures clinical efficiency, or whether patients received care in a manner that is cost-effective for them.

For instance, it tracks emergency department visits by patients with asthma and diabetes.

"This metric should resonate with the other metrics. Patients who are well cared for should experience fewer emergency room visits than patients who aren't getting the care they need," Mirsky says.

The program tracks the rate at which physicians prescribe generic and preferred brand name drugs, resulting in lower out-of-pocket costs for patients. "We compare them to each other on a peer-to-peer basis to determine who is saving their patients more money," he says.

Rewards also will be based on the physicians' use of a secure web-based tool that allow patients to communicate with their physician offices for administrative services such as scheduling appointment, requesting prescription refills, and getting normal lab results.

Blue Cross and Blue Shield of Florida partnered with Relay Health of Emeryville, CA, to develop the tool, which also includes paid e-visits for established patients with nonemergency conditions.

Patients who log onto the HIPAA-compliant web site go through an algorithm that asks specific questions about their condition and past medical and medication history. The physician replies to the patient using the same web site with specific instruction that may or may not include a prescription.

"Our clinical efficiency measures focus on what is most efficient for the members. This category rewards physicians for reducing the amount of time the patient has to spend on the telephone and when members can stay home or on the job while getting advice about nonemergent care," says Mirsky.

The system also measures the physician's participating in administrative tools, such as electronic claims submission and updating or validating their information in the company's directory to make sure the members have the most up-to-date information.

The Institute of Medicine's groundbreaking report *Crossing the Quality Chasm: A New Health System for the 21st Century* was part of the impetus for the insurer to create the program, Mirsky says.

"The report identified pay for performance as one of the cornerstones of improving quality of care and closing the gap," he says.

Blue Cross and Blue Shield of Florida studied pay-for-performance practices of other health plans before designing its own plan. It is the first program that includes the company's commercial HMOs, PPOs, and other commercial lines of business.

"We believe that we have taken pay for performance to another level because our program is inclusive for all of our commercial lines of business. Our program not only increases the breadth of membership in other pay-for-performance programs but also the breadth of the types of indicators we monitor," he says. ■

GUEST COLUMN

CMs, disease managers should collaborate

Work together to develop health strategies

By **Diane L. Huber**, PhD, RN, FAAN, CNAA, BC
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As employers look at ways to deal with escalating health care costs, case managers likely will find themselves playing key roles. They will not, however, be the only ones in the game. Case managers complement disease managers as the two roles become integrated for more powerful care coordination.

Case managers likely will work in conjunction with disease managers as employers and their health plans launch comprehensive strategies to

coordinate care, eliminate costly duplicated or unnecessary services, and promote wellness and prevention in the workplace. In addition, case managers also will find opportunities to work in disease management themselves, broadening their services from dealing with individual patients to also looking at specific groups within an employee population.

Case management and disease management do overlap at times, but these programs are distinct and different. Disease managers focus on specific groups of individuals who have been diagnosed with or who run a greater risk of having specific diseases or health conditions, such as diabetes or heart disease. The Disease Management Association of America defines disease management as "a system of coordinating health care interventions and communications for populations with conditions in which patient self-care efforts are significant."

Case managers advocate for the individual who needs coordination of care because of a serious illness, accident or flare-up of an existing condition, which may be further compounded by other health issues (known as comorbidities). The Case Management Society of America defines case management as "a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes."

As case managers and disease managers work together, there are some important considerations:

• Employees and their dependents need to experience case management and/or disease management as part of a seamless, integrated program, often with a single point of contact. Without a single point of contact, there can be confusion over whom to call and for what reason, which frustrates employees and makes these programs less effective.

• Although the employee experience may be seamless, behind-the-scenes case managers and disease managers need clear lines of demarcation for handling calls. A communication plan or map can delineate how calls from employees and their dependents are routed and referred.

• Communication and coordination among disease managers and case managers are essential, based on an understanding and appreciation of each other's expertise.

Importantly, case management and disease management services must be administered in the right dosage. This involves the right amount and type of patient intervention, at the right time and with the right frequency.

With a foundation of cooperation, communication, and understanding, case managers and disease managers can come together under a common umbrella of "care management," as many employers are calling these integrated programs. Then as a patient's health needs change, disease managers and case managers can work together to provide the specific services as needed in the most integrated and holistic manner.

For example, a person with diabetes may be enrolled in a disease management program, with education on diet, self-care, and wellness. Should that person suffer another health event — such as a heart attack — the case manager can step in as an advocate for the patient, coordinating care and ensuring that the right treatment is provided at the right time. When the patient is stabilized, the case manager may close the case, at which time the disease manager may take over again with education and support.

Given employers' desire to reign in their costs for health benefits, one would expect to see more coordinated services. Clearly, this calls for case managers with their expertise as advocates for patients, and while conserving scarce and costly health care resources, to be instrumental as good stewards of resources and encourage applicable strategies. At the same time, case managers will work more closely with disease managers who focus on specific groups within a population. Together, they will promote optimal health and wellness of individuals — and better outcomes for employers looking to control costs.

[Editor's note: Diane Huber, PhD, RN, FAAN, CNAA, BC, is the Immediate Past Chair of the Commission for Case Manager Certification (CCMC). She also is a professor at the University of Iowa College of Nursing, teaching case management courses, an investigator at the UI Center for Addictions Research, Institute for Strengthening Communities, and has a secondary appointment at the UI College of Public Health Department of Health Management and Policy.

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The CCMC is the first and largest certifying body for case management professionals to be accredited by the National Commission for Certifying Agencies.

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Tailor diabetes education to specific ethnic groups

Impact risks with same message in different forms

It is a well-known fact in the health care community that there are diabetes disparities among ethnic groups. Diabetes is a problem throughout the United States. An estimated 18 million people suffer from the chronic disease, and people of color are more likely to develop Type 2 diabetes. This includes Native Americans, Alaska Natives, African Americans, Hispanic/Latinos, Asian Americans, and Pacific Islanders, according to statistics gathered by the Atlanta-based Centers for Disease Control and Prevention (CDC).

Because of their increased risk, many individuals within these groups have a fatalistic attitude about developing the disease. However, an increased risk shouldn't be viewed with fatalism but as a call to action, says **Jane Kelly**, MD, director of the CDC National Diabetes Education Program.

In the past, an attitude of fatalism was pervasive among American Indians and Alaska Native populations who believed that, no matter what they did, they would develop diabetes, says **Carol Maller**, MS, RN, CHES, diabetes project coordinator at Southwestern Indian Polytechnic Institute in Albuquerque, NM. "Today, we know the importance of prevention in overcoming lifestyle diseases and diabetes is no exception. Type 2 diabetes can be prevented or delayed by making healthy choices — that is the message," she says.

The core message is the same for everyone, agrees Kelly. Environment and socioeconomic constrains and implications are often far more important than genetics. Being overweight and having a sedentary lifestyle increase a person's risk for developing diabetes.

While the message is the same for everyone, the way it is delivered is not. While developing educational materials specific to various ethnic groups for the National Diabetes Education Program, work groups had to consider many factors. For example, the perception of being overweight differs among ethnic groups. African American and Caucasian women have different perceptions of what constitutes being overweight. Therefore, many would not be aware that they are at increased risk for diabetes because of their weight. This information was uncovered in focus group research, says Kelly.

Studies have determined that Asians are at risk for diabetes at a lower body mass index (BMI) than Caucasians. For many, a BMI of greater than 25 increases a person's risk for diabetes. However, for Asians, a BMI greater than 23 is the cutoff point, she explains.

Understanding that barriers to change of lifestyle differ from group to group is also important. For example, many older adults think they can't be more physically active because of ailments such as arthritis. Therefore, it is important to help them understand that they don't have to run a marathon to be physically active.

For Asians, the barrier to exercise is time. "Clearly, you hear that from anyone, but it came out very strongly in our Asian work group," says Kelly. When tailoring education on diabetes prevention to ethnic groups, it is important to consider their perception of risk factors, barriers to lifestyle change, and what motivates them, she explains.

Maller oversees a program that was developed to prevent diabetes among Native Americans by introducing diabetes-based science education in tribal schools. "The goal is to integrate principles of diabetes prevention into the existing school curriculum at a very early age and reinforce the message throughout the formative years of schooling, K-12 grades. Taking patient education out of the clinical arena and bringing it into communities is the focus of this early intervention," she says.

Community involvement

To eliminate health disparities, minority community involvement is essential. "American Indian and Alaska Native cultural traditions and knowledge affect their health beliefs and behaviors, and each tribal community needed to be represented. Understanding the beliefs, values, traditions, and practices of a minority culture was necessary to develop working relationships for curriculum development and implementation," says Maller.

The diabetes curriculum for tribal schools is

designed to engage teachers and students in activities that make a difference in preventing diabetes. For example, a Walking Unit using pedometers has been developed for middle school students to count steps to learn about the importance of increasing activity. Students take the message home and soon entire families are out walking in their tribal communities. Students are given water bottles with the amount of sugar in the same quantity of soda imprinted on them in an effort to encourage children to drink more water. The activity corresponds to a lesson plan on hidden sugar.

To determine what type of prevention education would work with local populations, Kelly advises patient education managers to assemble focus groups. "Focus group testing is not something that you need a sophisticated research grant for. It could be as simple as getting five to eight people from your clinic together and asking their opinions on materials," she says.

The proper tools for change

States have diabetes prevention programs that target ethnic populations that have settled there and are a good source for information, she notes. For example, many Haitians have immigrated to Florida; therefore, that state would have information on that particular ethnic group. In addition, the National Diabetes Education Program has developed pamphlets that target ethnic groups and are written in several languages.

Providing people with the proper tools to make changes is also important, says Kelly. In a game plan toolkit created by the National Diabetes Education Program, there is a fat and calorie counter and a food and activity tracker. These tools help people monitor the small lifestyle changes they are making and motivate them to continue their efforts to improve their health. Weight loss often is used to monitor progress, and it can take quite a while to see a difference. In the meantime, people can become discouraged and return to their unhealthful habits.

Tailoring the message of diabetes prevention to special populations in their native language with respect for their cultural heritage is critical, notes Maller. It also is important to identify influential community leaders to carry the message back to their communities. "We cannot afford to overlook cultural heritage as we work to restore a culture of health across the country," she says. ■

Hands off or on when it comes to patient care?

Offering comfort can be thwarted by culture

For as long as humans have been taking care of other humans who are sick or hurt, the rendering of solace and physical comfort has been the core from which all other types of aid have grown. But a nurse and ethicist in California says that ignoring the value of giving of solace and comfort amounts to turning away from the prime reason for the practice of medicine.

Rapid advances in technology, cultural differences between nurses and patients, and the current nursing shortage all have contributed to a hands-off approach by some nurses, says **Patricia Benner**, RN, PhD, professor in the department of social and behavioral sciences and the department of physiological nursing at the University of California at San Francisco. "One colleague felt like it didn't occur to nurses to reach out physically to patients and to offer comfort other than medication, and I think that's a real deterioration of the practice," she adds. "It's a loss of self and ethos of the practice."

Benner disagrees with the opinion that nurses are not being taught in school the value of being there for patients, or presencing (being present and available to the patient) oneself and offering comfort. But she agrees that cultural differences and concerns about the possibility of unwelcome touch possibly offending the patient or family members have led some nurses to not engage in hands-on comforting.

Individual decisions

Offering comfort of the human type, and not just medications and technology, is what nursing always has been about, says Benner, a belief echoed by American Hospital Association president **Dick Davidson**. "There will always be personal contact and caring," he says. "We will always have hands touching patients. Everything we do is about human need. That's the constant over time."

Nursing and medical students still are being taught the arts of gentle touch and hands-on comfort measures, such as simply being present in a reassuring manner, says Benner, who works as a consultant in the development and enhancement

of delivery of nursing care. "However, there are threats to this central nursing practice. It is invisible; it is rarely charted; and it is never mentioned in a nursing care plan."

This leaves nurses to decide individually, patient by patient, what role comfort and presencing will play. Just how much physical comfort a nurse should impart on a patient, if at all, largely will depend on the patient. "It *always* has to be lodged in the relationship," Benner stresses. "Just as you can't suggest that you'll do it for all patients, it would also be very wrong to say you won't do it at all. And of course, if a patient does not want comforting, it would be wrong to force it," she adds.

Cultural diversity plays a role, as well; some cultures have deeply ingrained attitudes toward physical touching. "You have multiculturalism on the side of both nurses and patients, and both groups are diverse [in their ethnicities]," Benner says. "The language of presencing and comforting practices are deeply cultural, and there are even status barriers that might prevent a nurse from offering solace or prevent the patient from accepting it."

She adds that for medical staff to know how to give a patient the comfort and solace he or she needs, and to the degree that he or she needs it, the clinician must first get to know that patient to determine what his or her needs and preferences are.

Staffing issues

Staffing can have an impact on what kind of care can be rendered. If manpower is short, so is the time a nurse or physician can spend with individual patients. "If you are short-handed, there isn't going to be lots of time for sitting with a patient, listening, just presencing," Benner points out. "But with adequate staffing, there's no reason comfort and caring can't be part of the delivery of care."

Delivery of comfort is taught in medical and nursing schools and is an integral part of the ethos of the practice, she adds. "You really couldn't have good judgment or trust without good relational care, at least in some specialties."

One specialty, in particular, gets it right when it comes to giving patients individualized, hands-on, comforting care. "I've always felt it was very sad that veterinarians give much more individualized care to their patients than we who take care of humans," says Benner. Without that human element — the willingness to sit and hold a patient's hand, to listen, to massage cramping legs or bed-weary backs — "we have nothing but a technical enterprise of delivering goods and services to patients."

When someone is ill, she says, that person needs more than just the best drugs and most advanced treatment available. "They need more than justice and rights; they need comfort and goods."

Simply being there for a patient, even without offering anything in the way of real care, becomes more difficult as facilities continue to struggle with staffing. But it's a care delivery method that patients really shouldn't have to do without, Benner says.

"Presencing yourself when someone is in distress — not abandoning them — is a very important comfort strategy," she adds. "This is especially true when someone is trying to get his own equilibrium back, regulate his breathing, get his heart rate back in tow. "Just having someone with them can be a real source of comfort," Benner stresses. ■

Opportunistic infections remain a key problem

Comorbid conditions growing in importance

Although the most common reasons for hospitalization among HIV patients in six hospitals nationwide are for comorbidities, there remains a significant rate of hospitalization for opportunistic infections (OIs), a new study says.

Investigators analyzed hospitalization rates for more than 10,000 patients, with a median age of 41, at six hospitals across the country, where there were large samples of HIV-positive patients who were part of the HIV Research Network, says **Kelly Gebo**, MD, MPH, assistant professor of medicine at Johns Hopkins University, School of Medicine in Baltimore. The study was presented at the recent 2004 annual meeting of the Infectious Diseases Society of America, held Sept. 30 to Oct. 3, 2004, in Boston.

In 2001, 17% of the cohort had one or more hospitalizations, and 23% of all hospitalizations were for AIDS-defining illnesses, she says.

The same data showed that 10% were for gastrointestinal problems, 9% for mental health problems, and 7% for circulatory disease, Gebo adds.

"Hospitalizations for opportunistic infections [OI] were higher than we anticipated. And these rates were higher in women and Hispanics. The next most common reasons for hospitalization were gastrointestinal disease, mental health problems including substance use, and circulatory disease, including cardiovascular disease," she says.

"Women had higher rates for gastrointestinal and mental health disease, but lower rates for circulatory problems," Gebo adds.

The most common reasons for hospitalization among those who had OIs were *Pneumocystis carinii* pneumonia (PCP) and bacterial pneumonia, she explains.

Pneumonia diagnoses were higher than researchers had expected, and this indicated a shift in HIV disease progression, Gebo notes.

"People are getting immune benefit from highly active antiretroviral treatment (HAART), but they're still showing bacterial infections," she says. "They're getting fewer traditional opportunistic illnesses, but the most common new OI is bacterial pneumonia."

Recurrent bacterial pneumonia was the most common of AIDS-defining illnesses, with a hospitalization rate of 3.86 per 100 patient years; PCP, by contrast, had a hospitalization rate of 1.63 per 100 patient years, Gebo says.

"I think recurrent bacterial pneumonia is more common in older people, and this reflects that our patients are getting older," she notes.

When data were adjusted for CD4 cell counts and viral load counts, it was found that patients with lower CD4 cell counts and higher viral loads were more likely to have AIDS-defining illnesses, just as might be expected, Gebo points out.

"And those on antiretrovirals were less likely to get AIDS-defining illnesses than those not on them," she adds. "Also, people who had more visits to their doctor were more likely to have AIDS-defining illnesses."

Other findings included these:

- Hispanics had higher rates of hospitalization for AIDS-defining illnesses than did whites or African Americans.
- African Americans were more likely to be hospitalized for a mental health condition than were whites or Hispanics.
- Older patients were more likely to be hospitalized for a circulatory disorder and for gastrointestinal disorders but not for AIDS-defining illnesses or for mental health conditions.

The hospitalization rates for substance-use disorders also were surprisingly high, Gebo says.

"I think a lot of our patients are actively using illicit drugs, causing toxicity, and needing hospitalization," she says.

Substance use had a hospitalization rate of 1.42 per 100 patient years, which was the highest rate among non-AIDS-defining illnesses, Gebo adds.

"I think there are two messages in these findings," she says. "One is that patients are suffering from traditional OIs less than they were before, and bacterial pneumonia is now the most common AIDS-defining illness and, two, patients are hospitalized for multiple comorbidities, with mental health, circulatory, and GI [gastrointestinal] the most common."

As HIV patients age, clinicians should expect to see more general comorbidities, including heart attacks, strokes, hepatitis-related complications, and substance-abuse disorders, Gebo says.

"They need to be aware of the fact that HIV patients will have general health problems that could be a result of therapy or the normal processes of aging, but we'll be seeing more and more of these things," she adds. ■

NEWS BRIEFS

Practice strategies don't affect diabetes care

A Harvard Medical School study has found that current practice management strategies and financial arrangements have a limited impact on the quality of care for patients with diabetes. Led by Nancy L. Keating, MD, researchers reviewed medical records of 652 diabetes patients enrolled in three health plans in Minnesota along with the 399 physicians in 135 practices who cared for them.

Researchers defined the main outcome measures by a quality score indicating receipt of care in accordance with six accepted quality indicators.

Only 5% of the variation in quality was attributed to characteristics of physicians' practices. Quality scores tended to be higher for patients whose physicians received quality performance reports or utilization profiles from more than one source, routinely enrolled diabetic patients in disease-management programs, or received diabetes-specific reports.

The study, *The Influence of Physicians' Practice Management Strategies and Financial Arrangements on Quality of Care Among Patients With Diabetes,* is available in the September issue of *Medical Care,* the journal of the American Public Health Association. ▼

Survey reveals hospital outpatient surgery decline

In a continuation of a trend of outpatient surgical procedures moving from hospitals to surgery centers and physician offices, hospitals reported a 1.1% decline in the percentage of outpatient surgeries performed at hospitals in 2003, the first drop in more than two decades, according to the latest annual survey from the American Hospital Association (AHA).

"In 1980, more than 90% of outpatient surgeries were performed in hospitals," says **Caroline Steinberg**, vice president for trends analysis for the AHA in Washington, DC. "By 2003, 47% were performed in hospital outpatient departments, 37% were in freestanding centers, and 16% were in physician offices."

Kathy Bryant, executive vice president of the Federated Ambulatory Surgery Association, says some large-volume procedures such as endoscopies and pain management may be moving to physician offices. "Physicians have long complained that they have difficulty scheduling these procedures in hospitals due to poor reimbursement," Bryant says.

The future movement of outpatient surgery is uncertain, Steinberg says. "Technology will continue to probably allow more patient surgeries to be provided in an outpatient setting," she says.

Bryant agrees. "As technology continues to improve, procedures will move to outpatient settings, and some projections suggest huge growth in surgical demand," she says.

Where that surgery will be scheduled remains to be seen. "In some areas, we have heard of hospitals scheduling outpatient surgery at 10 p.m.

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due to limited capacity," Bryant says. "If outpatient operating rooms are full, then I would expect to see movement to other sites." ▼

CBO: Jury still out on disease management

Insufficient evidence exists to prove that disease management programs can lower overall health care costs, concluded the Congressional Budget Office (CBO) in an Oct. 13, 2004, press release.

The CBO based its analysis, conducted at the request of Senate Budget Chairman Don Nickels (R-OK), on a review of medical journal studies on disease management programs for congestive heart failure, coronary artery disease, and diabetes.

The CBO found that few studies directly addressed the costs of such programs, and those that did failed to capture all forms of health care spending, excluded administrative costs, did not consider the unintended consequences of intervention and were conducted in limited, controlled settings.

If applied to a broader population, the programs actually could increase health costs, the report said.

The CBO also found little evidence to address obstacles in translating disease management into savings for Medicare, including an older, sicker population and the current fee-for-service system. ■

CE questions

1. Paul Serini, executive vice president of XLHealth, credits what type of intervention for the company's success in dramatically reducing amputations and health care costs for patients with advanced congestive heart failure and/or complex diabetes?
A. Face-to-face interventions
B. Telephonic interventions
C. Both A and B
D. Neither A nor B

2. Blue Cross and Blue Shield of Florida's Recognizing Physician Excellence program rewards physicians based on which of the following criteria?
A. Patient satisfaction
B. Clinical quality and efficiency
C. Administrative efficiency
D. All of the above

3. The Case Management Society of American defines case management as "a system of coordinating health care interventions and communications for populations with conditions in which patient self-care efforts are significant."
A. True
B. False

4. For Asians, a body mass index greater than ___ increases the risk of diabetes.
A. 21
B. 23
C. 25
D. 27

Answers: 1. A; 2. D; 3. B; 4. 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. ■