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# Case Management ADVISOR™

*Covering Case Management Across The Entire Care Continuum*

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# 'Next Generation Care Management' cuts costs, increases satisfaction

*Savings per catastrophic case increased by 300%*

Using a comprehensive approach to care management called "Next Generation Care Management," BlueCross BlueShield of Tennessee has cut both the number of catastrophic case managers and the average caseload while increasing the savings per catastrophic case by 300%.

At the same time, staff turnover has dropped by 10%, member and provider satisfaction have improved, and the company predicts it has saved millions of dollars by increasing patient compliance with treatment protocols.

Next Generation Care Management uses predictive modeling to stratify members into risk levels and triage interventions to the appropriate level of care — lifestyle and health counseling; care coordination; and catastrophic case management.

The predictive modeling tool embedded in MCSource, a decision-support system from Baltimore-based VIPS Inc., has enabled the health plan to use predictive modeling for the care management processes. The predictive modeling includes ICD-9 codes, members' ages and genders, and cost of medical care and pharmaceuticals, and stratifies members into five categories, based on the predicted cost of future health care.

The predictive model allows the health plan to look at projected costs for members in the future and intervene earlier, saving health care costs and improving members' quality of life.

Instead of waiting for claims to identify members who might be eligible for care management, the process starts when the utilization review nurse receives a call to pre-certify a patient's medical care.

"We want to be more proactive than just taking members from a list and putting them in care management. This unique approach is much more effective than just identifying members after the claims come in, when we may have lost the opportunity to impact their care," says **Sylvia Sherrill**, RN, MS, director of health care services operations.

The pre-certification nurses examine the members' predicted cost of

care, factor in any additional conditions or illnesses, and refer members who may be eligible for care management to the care management triage team, where they are placed in the appropriate level of care.

Risk Level 1-2 includes members whose health care cost in Year 2 is predicted to be between $1,000 and $5,000. These receive lifestyle and health counseling, including material by mail and referrals to Internet and telephonic resources.

Risk Level 3-4 includes members whose health care costs are predicted to total from $5,000 to $25,000 in Year 2. These members are referred to one of six care coordination programs in which nurses assess and monitor their conditions and provide telephonic care coordination.

Risk Level 5 includes members whose health care costs in Year 2 are estimated to be greater than $25,000. They are referred to catastrophic case management for intensive case management in a program that has been accredited by URAC.

Before the health plan began its Next Generation Care Management Program in April 2003, the company offered only catastrophic case management to members who were referred through a trigger list and reports of cases with high costs.

"The program was effective for members with a catastrophic illness but was not appropriate for those members who would benefit simply from education, information, and lifestyle counseling," says **Soyal Momin**, MS, MBA, manager of research development and consulting for the Chattanooga, TN-based health plan.

Before the predictive modeling program was begun, many patients were being referred for case management when case management interventions wouldn't have any impact on their care. For instance, people in motor vehicle accidents were on the trigger list for case management; but if their injuries were not catastrophic, there was little the case managers could do.

Another example is patients who had a stroke, were treated in the emergency department and released, and expected to recover fully after a few physical therapy sessions.

"Our case managers were spending about half their time investigating and assessing cases when they couldn't have any impact," Sherrill says.

With the new predictive model, the health plan was able to establish the lifestyle counseling and care coordination programs and redeploy about one-third of its catastrophic case management staff to staff them.

"We are touching so many more lives. In the past, if a member didn't need a high intensity of care, we would just close the case. Now patients who are at low risk and medium risk are receiving interventions that we hope will help them avoid becoming high risk," Momin says.

The Next Generation Care Management initiative allows some members to be referred to case management proactively, before an episode of care, rather than after the claim has been processed, sometimes as long as three months.

"In the past, it often was too late to intervene due to the disease progression, leaving little room

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## Editorial Questions

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for improvement and missing the window of opportunity for savings," Momin says.

In addition, members who are identified by claims data because they have experienced the most costly claims in the past are not necessarily those who are likely to have high future costs, he points out.

When a physician's office calls to pre-certify a patient's treatment, the pre-certification nurse accesses the member's predictive modeling score and adds to it the information he or she receives from the physician office.

"The nurses often pick up additional information that's not in the database when they talk to the doctor," Momin says.

For instance, the predictive model would show if the member has diabetes and congestive heart failure, but it might not show depression if the claim medication for that condition hasn't been received by the health plan.

The nurse has the capability to supplement the prediction for depression resource requirements to the model and predict the costs identified with the new condition. The predictive model predicts resource consumption for the next two years.

"If we can get the members into case management as they come through the pre-certification process, while services are being rendered, we can be very proactive," Sherrill says.

If the predictive modeling data have stratified the member as being low cost and the nurse is being asked to certify a new episode of care that is likely to be high cost, the member is referred to case management.

If the member already has been stratified as high cost and has a new episode of care, he or she also is referred to case management.

"When the pre-certification nurse adds information about the member's new episode of care, it usually increases the stratification of the member and may change how we handle that patient," Sherrill says.

Members whose initial predictive modeling stratification and current episode of care identify them as being at risk are referred to a triage unit where the nurse pulls all the patient information together and steers them into the program they should be in.

"We are putting tools in the hands of nurses to allow them to intervene earlier and coordinate the members' care," Sherrill says.

Members with a low score receive basic education through mailed materials.

The health plan refers members stratified as moderate to programs that can make an impact.

BlueCross BlueShield of Tennessee already has developed six care coordination programs and is working on several more in which RN case managers assess and monitor diseases and conditions and provide telephonic care coordination, working with the members and their physician. These include pharmacy care management, emergency services management, Centers of Excellence, transition of care (formerly known as discharge planning), condition-specific care coordination, and disease management.

The pharmacy care management program includes a program to ensure members with hepatitis C receive the optimum length of drug therapy; a program to encourage compliance with beta-blockers after a heart attack; a migraine care management program; and a polypharmacy care management program.

Members who frequently use the emergency department are referred to the emergency services management program and receive counseling from an RN with psychiatric training and guidance on appropriate care options.

The health plan's Centers of Excellence program has identified physicians who provide cost-effective and quality care for members with asthma, diabetes, congestive heart failure, coronary artery disease, and chronic obstructive pulmonary disease.

The transition of care program aims to reduce the length of stay, costs for per diem admissions, and readmissions, and provide a smooth transition of care.

The insurer also provides in-house care coordination for some chronic conditions and disease management services, through LifeMasters Supported SelfCare, Inc.

Patients who stratify as high cost are referred to catastrophic case management for a detailed assessment, a care plan, and more frequent follow-up. "This is the area where interventions have the most impact on efficiency and savings," Sherrill says.

The predictive model actually has helped reduce the staff in catastrophic case management because of the reduced number of cases.

In addition, because all the cases now handled by the catastrophic case managers need intensive case management, the average savings per case manager's caseload has gone up 300%.

"The significant number of cases that were not impactable were diluting savings. The case managers still had to make an assessment on the cases that they couldn't impact. It cost us a great deal

of money to be ineffective," Sherrill says.

Other outcomes include a hepatitis C program that has generated $1.5 million per year in medication cost avoidance among patients in the program and a $1.3 million per year cost avoidance for patients in the AMI beta-blocker program.

After two years experience of using predictive modeling for care management, the health plan is enhancing its predictive modeling capability with a Rational Artificial Intelligence (RAI) component that will help identify members who are low cost this year but can be expected to move into a higher cost bracket in the future.

The RAI index will identify gaps in care, such as lack of foot examinations for diabetics, and flag members who are beginning to show comorbidities.

"Artificial intelligence will pull together a full picture of someone who is just starting to use services that indicate his condition is likely to change," Momin says. ■

# How to tell clients what case managers do

*CMSA-led coalition establishes CM definition*

After an exhaustive process that involved collecting and evaluating more than 150 separate definitions of case management, the Case Management Leadership Coalition (CMLC) has come up with a statement designed to help case managers explain what they do:

"Case managers work with people to get the health care and other community services they need, when they need them, and for the best value," is the consumer-friendly definition selected after a year of work.

Because so many people call themselves "case managers" no matter what they do, the CMLC, a group of case management leaders who work in various settings, decided to come up with a definition that patients and clients could easily understand.

"There is still a lot of confusion among consumers and in the health care industry because of the many ways that case management is defined. Even though the CMSA Standards of Practice clearly define case management, it doesn't stop people from using the term to mean other things," says **Jeanne Boling**, MSN, CRRN, CDMS, CCM, executive director of the Little Rock, AR-based Case Management Society of American (CMSA).

The group set out to identify the skill sets and knowledge that case managers have so that case managers will be identified by what they actually do, rather than just a job title that can encompass a lot of different things, she adds.

The leadership coalition asked patients and clients to complete the statement: "I know my case manager has done a good job, because . . ."

Responses included: they help me understand, they educate; they provide options; they coordinate; they listen; they help; they support; they negotiate.

After developing the definition, the coalition tested it with people in different populations — Medicaid and Medicare recipients and the commercially insured — and found it to be user-friendly.

Case managers can use the consumer definition of care management in many ways, Boling says. For instance, they can use it to explain their job when they meet a new patient or client. They can use it in advertising and marketing materials and incorporate it into letters introducing themselves to clients.

The CMLC began as a one-time event in 2002 and has evolved into an ongoing group that meets every six months to discuss issues and trends affecting case management and ways case managers in all settings can collaborate to improve patient care, Boling says.

The coalition is led by CMSA and the Academy for Certified Case Managers. ■

GUEST COLUMN

# Understanding DM helps case managers do their job

*Complementary practices combine for better care*

By **Diane L. Huber**, PhD, RN, FAAN, CNAA, BC
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The term "disease management" has grown in popularity and widespread usage over the past decade to the point that it is assumed most

case managers and related professionals know exactly what this term means. Although case managers may believe that they understand at least the basics of disease management, it is important to step back and carefully consider its definition and protocols.

Disease management has evolved since the mid-1990s, becoming more sophisticated and statistically rooted, with tracking mechanisms to measure approaches and outcomes. Similarly, the field of case management also continues to change as it is practiced in a wider variety of venues.

Given the dynamics of the two fields, case managers would benefit from a good working knowledge of disease management. Especially important is the use of evidence-based practice for the treatment of specific diseases.

Looking at the term literally, disease management would appear to mean the management of diseases (just as case management seems to refer to the management of cases). However, this is far too simplistic and limited a view. For one thing, seeing disease management only from the perspective of the disease would put it primarily in the domain of physician practice. The Disease Management Association of America (DMAA) sees disease management as multidisciplinary, although medical care is a central component.

Moreover, disease management focuses on individuals or groups of people who are affected by specific health issues. These include chronic diseases such as diabetes, cardiovascular disease and hypertension; medical conditions such as obesity or high-risk pregnancies, and behavioral issues such as depression. As the DMAA states, "Disease management is a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant."

What then are the implications of disease management on case management? The case manager's primary responsibilities are to act as an advocate for the patient and/or family and to provide access to the right care and treatment resources at the right time in a cost-effective and efficient manner.

As the Case Management Society of America (CMSA) defines the practice, "Case management is 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."

Clearly, case management and disease management are complementary. Case management focuses on the needs of the individual, and disease management emphasizes the treatment and prevention of specific diseases that affect an individual or particular population. Effective programs will blend the two practices, building on the strengths of each. Additionally, case managers can draw upon the tools and techniques of disease management to enhance their ability to advocate for patients and allocate appropriate care and treatment resources.

Among the sophisticated processes that have emerged in the field of disease management is evidence-based practice, which draws upon the current best evidence from systematic research in clinical practice. This research-based evidence then is used in conjunction with clinical judgment in the assessment and management of individual cases. As case managers work with patients who may have one or more chronic conditions — particularly in light of the aging population — it is essential to become knowledgeable about evidence-based practice.

Fortunately, there are resources readily available for case managers to access reliable and accurate information about evidence-based practice related to specific diseases. The Agency for Healthcare Research and Quality (www.ahrq.gov), for example, provides access on-line to information and evidence-based practice protocols in a variety of clinical categories, including cancer and blood disorders, heart and vascular diseases, musculoskeletal disorders, and pediatric conditions.

By accessing this information, case managers can avail themselves of the latest accepted best practices in the field and fulfill continuing education goals. For certified case managers (CCMs), becoming educated in best practices also will enhance their knowledge, experience, and distinction. The CCMC, which is the first and largest nationally accredited organization to certify case managers, requires CCMs to commit to continuing education in order to maintain their certification.

Greater understanding of disease management will complement the knowledge and experience of case managers today. Using the evidence-based approach emphasized in disease management, case managers can better educate patients and their families about the diseases and health conditions they face and the self-care options available to them.

*[Editor's note: Diane Huber, PhD, RN, FAAN,*

*CNAA, BC, is the immediate past chair of the CCMC. She also is a professor at the University of Iowa (UI) 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. She also is the author/editor* of Disease Management: A Guide for Case Managers *(February 2005, Elsevier).*

*The CCMC is the first and largest certifying body for case management professionals to be accredited by the National Commission for Certifying Agencies. URAC also has determined that the CCM credential is a recognized case management certification. For more information, contact the Commission for Case Manager Certification at (847) 818-0292 or visit the CCMC web site at www.ccmcertification.org.]* ■

# Technology, planning key to successful programs

*Program reduces readmissions by 70%*

While the Centers for Medicare & Medicaid Services (CMS) introduces new programs designed to address the care of chronically ill patients, home health agencies continue to find innovative ways to provide care to diabetic and congestive heart failure (CHF) patients — two of the most common diagnoses identified as chronic illnesses.

"We provide care to 4,000 patients, and half of them are considered chronically ill," says **Ray Darcey**, vice president of Sentara Home Care in Chesapeake, VA. "The most common diagnoses are diabetes, CHF, and chronic obstructive pulmonary disease [COPD]," he says.

After identifying CHF patients as the group for which costs were increasing and reimbursements were decreasing, Darcey's agency evaluated different ways to continue providing quality care at a lower cost. "We do have standard protocols that we follow for all of our chronically ill patients, and those do streamline our care. But we wanted to see if telemedicine would help us reduce our labor costs," he notes.

The telemedicine program for CHF patients was introduced four years ago. "The program involves a combination of telemedicine and nursing visits," Darcey explains. "The telemedicine visits are designed to supplement — not completely replace — nursing visits. Our program is a live, interactive video that requires a computer screen and a telephone line," he says. "The patient's unit has a blood pressure cuff, a scale, and a stethoscope that are used during the telemedicine visit with the results appearing on the nurse's screen," Darcey points out.

### Comprehensive education

Although the program has reduced staff costs because nursing visits to the home can be reduced, it also has produced some other significant results, he says. "We've seen a 70% reduction in hospital readmissions, a 78% decrease in emergency department visits, and a 50% improvement in activities of daily living for our CHF patients on the telemedicine service," Darcey notes.

The 60 patients on Sentara's telemedicine program are between 65 and 80, and none of them were apprehensive about the use of the telemedicine equipment, he says. "There was no hesitation, and we've discovered an unexpected bonus to the telemedicine program," Darcey adds. While the patients were not nervous about the equipment's digital camera sending their image to the telemedicine nurse, they especially are careful about their appearance during the telemedicine visits, he points out. "When nurses go to the home to see these patients, many of them will still be wearing their pajamas.

"For the telemedicine visit, the patients dress up, put on makeup, and fix their hair," Darcey laughs. Their attitude also is different, he adds. "They take their responsibility for their care between visits very seriously, and they are diligent about recording the information the nurse will request during the telemedicine visit."

The telemedicine patients see this program as a way for them to participate in their care, and their attitude and approach to self-care have improved greatly, he adds.

Although Sentara did experiment with the use of the same nurse for both the telemedicine and the in-home visits, Darcey notes it was not an efficient use of staff time. "Some of our patients live over 100 miles from the office with the telemedicine equipment."

Scheduling the nurses who cover these distant areas to come to the office to make telemedicine visits wasn't effective, he explains. "Patients don't mind two different nurses overseeing their care, and patient satisfaction scores for this group

of patients have increased."

In addition to having their own CHF program that includes comprehensive protocols and patient education, Sta-Home Health Agency in Jackson, MS, has targeted diabetic patients as one group to receive special attention to reduce complications and the need for hospitalization.

"We have a team approach to caring for diabetic patients that includes nurses, diabetic educators, and dietitians to make sure our patients receive the best education and care," explains **Michael T. Caracci**, chief executive officer. "All of our nurses are familiar with the potential complications and the neuropathy of diabetes, and we have seven certified diabetic educators on staff to serve as resources for the nurses and to visit patients," he says.

In addition to comprehensive patient education for his agency's own home care patients, Caracci's staff offer foot-care clinics through physician offices. The clinics are held in the physician's office for patients of that practice.

"One of our nurses, along with the physician, will talk to the group of patients about foot care in general for diabetics. Then our staff will work with each patient on an individual basis to trim toenails and check feet," he explains.

To avoid any Stark violations, the physician pays the agency on an hourly basis to provide the education and the foot care, he adds.

Because Caracci's agency covers a wide geographic area with 40 offices and more than 4,000 patients, it is not possible for diabetic educators to see every diabetic patient on a regular basis. That doesn't mean that nurses don't have access to the diabetic educators as a resource, he points out. "Although our nurses are well trained in the care of diabetic patients, there are times they may need advice," Caracci says.

Not only can nurses reach the diabetic educators by phone or e-mail but, if they are concerned about a patient's skin breakdown, nurses can give accurate information about the patient's condition with pictures. "We don't use telemedicine at this time, but we do have digital cameras in each of our offices that nurses can use to photograph a patient's wound and transmit the picture to the diabetic educator," he says. "This makes it possible for the educators to determine if the patient should be seen by another clinician or themselves for other treatment," he adds.

While technology such as digital cameras is affordable for most agencies, Darcey admits that telemedicine requires a significant investment.

"The cost of training nurses to use and set up the equipment in the patient's home is not much, but the equipment and software can add up," he admits. "We are fortunate that we are part of a larger health system with several hospitals. The reduction in readmissions and emergency department visits, and a shorter length of stay when hospitalization is needed for CHF patients combined to make a strong argument in favor of the investment in telemedicine," Darcey adds.

"We are planning to expand our telemedicine program to include COPD this year, and we expect to see positive results for those patients as well," he says.

## *In the patient's environment*

As CMS proceeds with chronic care improvement organizations and demonstration projects, some agencies such as Sta-Home will work with the chronic care organizations to provide the face-to-face visits required for some patients. "I think it is important to make sure that technology and emphasis on efficient care and education don't completely replace actual visits," says Caracci.

"There are things you learn about the patient when you are in the patient's environment that won't always be communicated because the patient doesn't consider them pertinent," he explains.

Caracci's favorite example of the importance of being in the home is his agency's experience with a diabetic patient whose blood sugar levels could not be controlled. Repeated visits to the patient and reinforcement of education were not working, so a nurse spent the entire day at the home to see if she could determine what the patient was doing, or not doing, to prevent control of her blood sugar level without sending her back to the hospital, he continues.

"Everything was fine from 8 a.m. until 3 p.m., with the patient eating correctly, checking her blood sugar, and doing nothing that explained her out-of-control blood sugar. At 3 p.m., the woman's granddaughter stopped at the house on her way home from school carrying the special treat she brought her grandmother every day — a Slush Puppie," Caracci says.

The nurse looked at the frozen, sweet drink and knew why the woman's blood sugar levels couldn't be stabilized. "The woman and her granddaughter never mentioned the daily treat because it never occurred to them that this one drink could cause so many problems," he adds.

"The nurse suggested other treats that the granddaughter could bring that wouldn't make hospitalization necessary." ■

# Integrated disability management a slow sell

*Pays off in savings on lost time, expert says*

Though research and anecdotal evidence seem to show that integrating disability and health care programs for all injuries and illnesses — whether suffered on the job or off — can get employees back to work more quickly, prevent absences, and lower total benefit costs, most employers are slow to warm up to the idea.

"We're probably 10 years into integrated disability management, and there still aren't as many companies doing it as all of us on the delivery side think there should be," says **Janet R. Douglas**, managing director for Marsh Mercer Inc., a global risk and insurance services firm. "For the companies that are, the results have been extremely encouraging in terms of reducing medical costs and lost time by applying best practices across the board, regardless of whether it's a work-related or nonwork-related injury."

Integrated disability management is a tool by which occupational and nonoccupational disabilities are approached consistently. Traditionally, injuries have been treated (with regard to benefits administration) differently, based on whether they occurred at work or at home.

"There have been huge variances in the amount of medical treatment and time lost from work, not based on the severity of the injury or illness, but based on the payment mechanism used," Douglas says. "Integrating your disability management takes a consistent protocol or approach to return to work; and applies it across the board, regardless of how or where the injury happened."

## *Evidence indicates benefits*

A study released in 2004 by Philadelphia-based CIGNA employee benefits company examined claims from 60,000 employees in 156 companies, and compared return-to-work times for employees whose benefits were integrated against employees whose benefits were not. The study showed that short-term disability ended sooner and employees returned to full-time work more quickly when they had integrated disability and health care programs.

Integrated disability management had its genesis with three large employers — General Electric, Ameritech, and General Motors — that looked at costs, saw that they were doing all they could to manage workers' comp and disability costs, and wondered why their health care costs continued to increase.

"They started working with industry thought leaders, and the question evolved: 'Why do we have this divide between occupational and nonoccupational disability?'" Douglas says. "Why not take the best practices from both and combine them, get the best treatments that are cost-effective and timely and that get the doctor reimbursed, and get the employee back in workplace as timely as possible and as strong and healthy as possible?"

She says while employers can agree that the idea is good — according to her, no large employer who has integrated its disability programs has failed to realize savings — the effort and investment required to make the change from an established benefits system is daunting.

"It's a huge effort," Douglas conceded. "It requires commitment and it requires investment and it requires someone high up enough to say, 'Let's do what's best for the company.'"

The larger the employer, the more likely it is to have an integrated disability management program. According to Watson Wyatt Worldwide, the number of employers in its annual survey that had integrated disability management programs increased from 26% in 1997 to 43% in 2001, and was almost 50% in 2004. The larger the company, Watson Wyatt reports, the more likely it is to have integrated disability management programs, also known as total absence management and health and productivity management.

According to Marsh Mercer's annual survey of employers about their time off and disability programs, lots of companies are integrating at least some parts of their disability programs.

The 2004 survey report showed that 62% of the 485 companies that participated in the survey use consistent occupational and nonoccupational return to work programs (up from 32% in 2000); 51% have integrated short-term disability and long-term disability coverage with one third-party administrator or carrier (up from 39% in 2000); and 42% use a single, centralized occupational and nonoccupational claim intake approach (up

from 32% in 2001). The Fourth Annual Marsh Mercer Survey of Employers' Time-Off & Disability Programs is available on-line at www.marshriskconsulting.com.

Douglas says tighter controls on workers' comp over the last 20 years, plus more scrutiny on Medicare, has led to elimination of costly tests and interventions that, in the long run, has resulted in longer recovery time and more lost work time. "There is an assumption on the part of some doctors that lost time doesn't cost anything, which is erroneous, of course," she says.

Getting employers — even ones who agree that integrating disability programs is a good idea in theory — to consider actually putting it into use within their own companies "represents a huge paradigm shift," according to Douglas. "Employers and workers are used to return to work for workers' comp, but not for short-term disability.

"They usually have workers' comp and disability managed internally through different groups and reporting through different avenues: workers' comp usually goes through risk management and finance, while disability goes to human resources."

When a changes as sweeping as integration of disability management programs is introduced, Douglas says she often sees a "push-back" from in-house medical departments.

"Any time you mess with someone's reporting systems, there will be some resistance," she says.

To demonstrate how an integrated system could save time and effort on everyone's part, and save money for the employer, Douglas suggests starting by measuring the number of lost work days — a huge cost to employers, but one that is not always well tracked.

"Measure workers' comp and short-term disability costs," she says. "We find one of the biggest challenges is tracking short-term disability, so an employer doesn't always know what they're spending in the first place. So in that scenario, tracking that information helps employers know what they have spent so they can have that benchmark going forward."

Medical costs associated with workers' compensation also should be examined.

"There's a learning curve, and you'll run into some issues around HIPAA [Health Insurance Portability and Accountabilty Act]," Douglas says. "People aren't used to being asked questions about nonoccupational injuries, so you have to do a lot of caretaking, making sure people's privacy is not invaded.

"People don't always understand why there's a difference in the way [disabilities] are reimbursed and why the paperwork involved is different. With integrated programs, there's a big increase in efficiency in the administration of the program."

And success stories are beneficial learning tools, too, Douglas says. According to the Integrated Benefits Institute (IBI) in San Francisco, Pitney Bowes Inc. reduced lost time by 42% in the first two years after it integrated its benefits programs and reduced medical costs by 25%. The company reported "virtually zero impact" on employee deductibles, copays, or other costs, according to IBI. ■

# Cooperative uses grant to evaluate quality plan

*Joint venture will involve academic researchers*

The University of Washington (UW) School of Public Health and Community Medicine in Seattle has received a two-year, $656,000 grant from the Robert Wood Johnson Foundation to evaluate the impact of Group Health Cooperative's recent innovations to improve access and quality of care for its members.

Group Health is a Seattle-based, nonprofit integrated health care system including one hospital, a number of outpatient clinics, physicians, and health plans that coordinates care and coverage for nearly 540,000 people in Washington and Idaho.

The study will review what Group Health calls its Access Initiative, a six-point plan to improve quality and access that has been rolled out over the past several years. The plan includes:

- offering patients same-day appointments to primary physicians;
- allowing patients direct access to most specialists, eliminating the need to go through primary care doctors to make appointments for specialty care;
- providing patients access to their own medical histories, appointment schedules, immunization records, and other health care information over a secure member web site;
- encouraging patient-physician e-mail communication via a secure web portal called MyGroupHealth;

• providing physicians and other providers with a $40 million clinical information system that offers up-to-the-minute patient health information, such as lab, X-ray, and pharmaceutical data;

• providing physicians with new incentives based on measures of productivity, cost, and quality.

"Our findings will be relevant to all people interested in issues of quality and access, regardless of what model of health care they represent," said **Eric B. Larson**, MD, MPH, director of Group Health's Center for Health Studies (CHS) and a co-investigator of the study, upon the announcement of the grant. "This is a seminal observation opportunity."

CHS conducts research related to prevention, diagnosis, and treatment of major health problems.

**David Grembowski**, PhD, professor of health services in the UW School of Public Health and Community Medicine, is the principal investigator. He and his colleagues will use Group Health's automated databases, member and physician satisfaction surveys, patient visit surveys, and in-depth interviews with care providers. Based on those data, they will determine how the access initiative is affecting factors such as cost, utilization of services, quality of care, member enrollment, and patient and provider satisfaction.

"We have a structured set of questions we will be asking," Grembowski explains. "First of all, we will look at what we call the 'take-up' of the initiative: Are they making same-day appointments? Are visits to specialists increasing? The second thing we want to look at is, did access actually increase? In other words, if you put this package out there in a group health system, is there actually an increase in access? Also, we want to see if satisfaction with care has increased as well. The final question we want to look at is, if we do find access has increased, is the quality of care better?"

Other UW researchers contributing to study will be Douglas A. Conrad, PhD, and Diane P. Martin, PhD. Other CHS researchers on the project are **Paul Fishman**, PhD, and James Ralston, MD, MPH.

## Full-range access

The leadership of the Group Health Initiative "is attempting to increase consumer access to the full range of preventive, palliative, and health services," Fishman explains. "This includes everything from primary care and prevention to palliation/hospice. And it's not simply to make sure the senior patients have access to their cardiologist, but that the patient has same-day access."

This part of the initiative has been in place the longest — since 2001, in fact. "To do it, they had to get rid of the backlog, so there was a short-term crunch," Grembowski notes. "But once you got over that, it was just dealing with the same-day appointments. The caveat is, you may not have the appointment with your personal primary care provider, but Group Health physicians work in clusters of three or four, so the appointment is kept within the cluster."

"I was not convinced as a consumer that this would be a big deal," Fishman adds. "But it really makes a difference — to be sitting there at midnight needing to see a doctor, sending an e-mail and having an appointment the next day."

The extensive electronic contact is significant, Grembowski adds. "Patients also have access to their electronic medical records over the web, and they can also do prescription refills.

"They can not only schedule office appointments on-line, but also obtain visit summaries. And if you are seeing a physician for a specific medical problem, the system will automatically send health care information about that condition to your e-mail address," he notes.

"The web-based initiative is, quite frankly, amazing," Fishman says. "Currently, about 30% to 40% of our patients are registered."

Financial incentives are another unique aspect of the initiative. For example, Grembowski adds, physicians get financial credit for responding to patients' e-mail messages.

"It's part of their compensation. Historically, Group Health physicians have been paid on a salary that was 100% guaranteed. Now, it's 80% guaranteed, and they can earn from 80% to 120% based on productivity, quality of care, and accuracy of coding," he says.

## Peer review imprimatur

The reason the Group Health has sought such a study, says Fishman, is quite straightforward: "We are trying to get this initiative to have the imprimatur of peer review," he asserts. "We want this work to be subject to that standard, and then to make sure the heath plan is responsive. When we say, 'Here's what we've learned,' we want them to be responsive to this."

The two-year grant ends November 2006. By that time, the researchers hope to gain understanding in several key areas: for example, whether physicians are responsive to alternative means of compensation and whether consumers are responsive to alternative venues of care, Fishman says.

"The literature shows that when the gatekeeper is eliminated, there aren't significant levels of change in care or in how people choose care. We have the opportunity to study these issues in ways others don't. Typically, these studies have only looked at physician care, but we can track how people move through the entire system." For health care quality professionals, he adds, the study should shed additional light on the relationship between health outcomes and quality measures.

"We will see whether there are relationships between all theses factors; we have a chance to do things others don't," Fishman concludes. ■

# NQF publishes report on cardiac surgery measures

The National Quality Forum (NQF) has published a new set of national consensus standards, "National Voluntary Consensus Standards for Cardiac Surgery," which provides a standardized set of measures and framework for improving the quality of cardiac surgery (which accounts for about 14,000 in-hospital deaths each year).

The report details quality standards endorsed by the NQFs more than 250 member organizations through its formal Consensus Development Process. As such, the measures have special legal standing as voluntary consensus standards.

The set includes 21 hospital-level measures that facilitate efforts to achieve higher levels of patient safety and better outcomes for patients. These measures are intended for public reporting.

The measures include:

- participation in a systematic database for cardiac surgery;
- surgical volume for isolated coronary artery bypass graft (CABG) and CABG+valve surgery;
- timing and selection of antibiotic administration for cardiac surgery patients;
- preoperative beta blockade;
- use of internal mammary artery;
- duration of prophylaxis for cardiac surgery patients;
- prolonged intubation;
- deep sternal wound infection rate;
- stroke/cerebrovascular accident;
- renal insufficiency;
- surgical re-exploration;
- antiplatelet and antilipid medications and beta-blocker at discharge;
- risk-adjusted CABG inpatient mortality;
- risk-adjusted operative mortality for CABG;
- risk-adjusted operative mortality for aortic valve replacement (AVR), mitral valve replacement/repair (MVR), AVR+CABG, and MVR+CABG.

The executive summary of the report with a list of endorsed performance measures can be found on the NQF web site at www.qualityforum.org. ■

## CE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a certificate of completion. ■

## *COMING IN FUTURE MONTHS*

- How rewarding physician performance can ensure your clients get high-quality care
- Why you should be concerned with pain management
- One health plan's initiatives to integrate case management and disease management
- Ways that specialty case management can positively affect the bottom line

# CE questions

17. In BlueCross BlueShield of Tennessee's Next Generation Care Management program, Risk Level 3-4 includes which members?
A. Members whose health care costs in Year 2 are estimated to be greater than $25,000.
B. Members whose health care costs in Year 2 are estimated to total between $5,000 and $25,000.
C. Members whose health care costs in Year 2 are estimated to total less than $5,000.
D. Both A and B.

18. The Case Management Leadership Council recently issued which of the following definitions for case management?
A. Case management is a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs.
B. Case management is a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant.
C. Case managers work with people to get the health care and other community services they need, when they need them, and for the best value.
D. None of the above

19. Which is **not** a result of the congestive heart failure telemedicine program implemented by Ray Darcey?
A. 45% reduction in claim denials
B. 70% reduction in hospital readmissions
C. 78% decrease in ED visits
D. 50% improvement in activities of daily living

20. According to Marsh Mercer's 2004 survey of employers about their time off and disability programs, what percentage of respondents indicated that they have integrated short-term disability and long-term disability coverage with one third-party administrator or carrier?
A. 62%
B. 26%
C. 43%
D. 51%

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



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## CE objectives

After reading this issue, continuing education participants will be able to:

1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how those issues affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities. ■