Case Management ADVISOR™
Covering Case Management Across The Entire Care Continuum

THOMSON
AMERICAN HEALTH CONSULTANTS

IN THIS ISSUE

Financial disclosure:
Editor **Mary Booth Thomas**, Editorial Group Head **Coles McKagen**, Managing Editor **Russell Underwood**, and Nurse Planner **Betsy Pegelow** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

OCTOBER 2006
VOL. 17, NO. 10 • (pages 109-120)

Diabetes management presents a costly challenge for health plans

Cost of epidemic exceeds $132 billion a year

Diabetes has reached epidemic proportions in this country. More than 21.8 million Americans have diabetes today, and an additional 42 million people have pre-diabetes and are at risk for developing the disease in the future, according to estimates from the Centers for Disease Control and Prevention (CDC).

In 2002, the last year for which data are available, the economic impact of diabetes exceeded $132 billion. Direct medical costs totaled $92 billion, with $40 billion in indirect costs, such as lost work days and disabilities, the CDC reports.

Since 1976, the death rate from diabetes has increased by 45%, during a period when deaths due to heart attack, stroke, and cancer have declined, according to the CDC.

According to a study by the Agency for Healthcare Research and Quality (AHRQ), fewer than half of adults diagnosed with diabetes say they receive all three of the yearly medical tests needed to manage the disease. Only 41.7% of those surveyed reporting having been checked for blood sugar level, diabetic retinopathy or other eye damage caused by diabetes, and foot and sore irritation, three tests considered critical for controlling diabetes.

"Diabetes is a silent killer in America. There is a big epidemic, and we are seeing significant increases in people with kidney disease and blindness related to diabetes. It represents a big cost to the American health care system and, as an insurer, it's a big cost to us," adds **Anthony Nguyen**, MD, MBA, FACHE, medical director for Blue Cross of California. The health plan targets pre-diabetics and members at risk for complications of diabetes for its individualized case management programs. **(For details, see related article on p. 113.)**

The problem is exacerbated by the fact that many people with diabetes have a limited understanding of diabetes and how it can affect them, according to the Diabetes Roundtable, a multidisciplinary group of

diabetes experts convened by the American Associa-tion of Diabetes Education and the American Association of Clinical Endocrinologists.

In a study commissioned by the group and conducted by Harris Interactive, half of the patients surveyed said they had little or no understanding of their hemoglobin A_{1C} level and were unsure if they had had it checked.

More than 80% of the physicians responding to the same survey expressed frustration with the number of their Type 2 diabetes patients who do not follow the treatment regimen.

The biggest challenge for diabetes disease management is that most diabetics are in denial. Patients with abnormal blood sugar levels often don't look at it seriously and realize the impact of what could happen to them if their blood sugar levels stay unchecked, points out **Lori Pennito**, RN, program coordinator for heart and diabetes program at ConnectiCare, a regional HMO with headquarters in Farmington, CT.

"Most of them are living their lives without noticing any effects of the disease. Vascular changes are silent until something catastrophic occurs. Our case managers try to help the members understand that diabetes is progressive and the disease's effects can be catastrophic," she adds.

ConnectiCare uses pharmacy data to identify members with diabetes and laboratory data to identify members whose blood sugar levels are above recommended levels to a case management program. **(For more on ConnectiCare's diabetes program, see p. 112.)**

The problem of out-of-control diabetes is more acute among minority populations, according to the AHRQ, which reports that, in comparison with non-Hispanic whites, blacks were almost five times more likely to be hospitalized for uncontrolled diabetes and Hispanics were 3.6 times more likely to be hospitalized.

Part of the problem is that health plans don't typically tailor their disease management programs to people from other cultures, says **Jon Shematek**, MD, vice president, quality and medical policy for CareFirst BlueCross and Blue Shield, an Owings Mill, MD-based health plan.

In an effort to improve the overall health of the community it serves, CareFirst is collaborating on a pilot project to improve diabetes care among patients at La Clinical Del Pueblo, a Washington, DC, clinic that provides care for a large Latino population. **(For details, see related article on p. 111.)**

"Our goal is to make sure these patients understand their disease and are taking steps to manage it. If a patient with diabetes doesn't receive evidence-based care, he is likely to incur tragic and expensive complications, such as blindness, heart attacks, stokes, amputations, and kidney failure," Shematek points out.

The American Diabetes Association recommends the following as "optimal" care for diabetics:

- a hemoglobin A_{1C} level of less than 7%;
- blood pressure less than 130.80 mmHg;
- use of a statin drug to normalize cholesterol levels;
- an LDL cholesterol level of less than 100 gm/dl and an HDL cholesterol level of $\geq$ 40 mg/dl for men

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

Subscriber Information

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

Subscription rates: U.S.A., one year (12 issues), $399. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. For approximately 18 CE nursing contact hours, $449. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $67 each. (GST registration number R128870672.)

Editorial Questions

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

Thomson American Health Consultants is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

Thomson American Health Consultants also is approved as a provider by the California Board of Registered Nursing (Provider #CEP10864). This activity is approved for 18 nursing contact hours. This activity is valid 12 months from the date of publication. Thomson American Health Consultants is approved as a provider by the Commission for Case Manager Certification for 18 clock hours.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: **Mary Booth Thomas**, (770) 934-1440, (marybootht@aol.com).
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@thomson.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@thomson.com).
Managing Editor: **Russ Underwood**, (404) 262-5521, (russ.underwood@thomson.com).
Senior Production Editor: **Nancy McCreary**.

and 50/mg dl for women;

- trigylcerides less than 150 mg/dl;
- a body mass index of less than 25 kg/m;
- use of baby aspirin daily;
- no smoking. ■

Program improves Latino population compliance

Insurer collaborates with free clinic to improve care

As part of its commitment to eliminating racial and ethnic disparities in health care, CareFirst BlueCross Blue Shield has launched a diabetes disease management program in collaboration with a Washington, DC, clinic that serves a mostly Latino population.

"The Latino population tends to do less well clinically and tend to adhere less closely to treatment guidelines for diabetes. Even in a majority white population, people with diabetes are far from being compliant. With minorities, we are lucky if we get 30% compliance with evidence-based guidelines," says **Jon Shematek**, MD, vice president, quality and medical policy of the Owings Mill, MD-based health plan, which provides coverage for members in Maryland, Washington, DC, Northern Virginia, and Delaware.

The health plan is collaborating with La Clinica del Pueblo on a pilot project to find out effective ways of improving diabetes care in a Latino population.

"The clinic has a large Latino clientele, with 90% to 95% of the patients preferring Spanish as their first language. Many of them have no insurance or are covered by public funding," he says.

The program is targeted to the community as a whole, not just patients that CareFirst BlueCross Blue Shield insures.

"This program is part of our commitment to improve community health. Most of the participants in this program are uninsured. Our intention is to prove that this model will work and build on it," Shematek says.

The health plan has received national recognition for a program that is ahead of the curve in terms of disease management for minorities, he says.

"If health plans are looking at changes in the demographics of the community they serve, this kind of program is good business," he says.

A large number of patients at La Clinica del Pueblo have diabetes and are not doing well when it comes to keeping their disease under control and staying out of the emergency department, he adds.

When the staff at La Clinica del Pueblo entered the information on the 150 patients in the pilot program from paper-based records into the database, they discovered that almost 30% had a hemoglobin A_{1C} level greater than 8 and that 13% had a level that was greater than 10, a clear indication that diabetes is out of control. In the previous year, only 30% had an eye exam and 10% did not have a blood test.

In the first nine months of the program, before all of the components were in place, the number of patients who had not had a hemoglobin A_{1C} test was cut in half and those with a good hemoglobin A_{1C} level had risen from 52% to well over 60%, Shematek says.

"We worked closely with the medical director and clinical staff to develop ways to improve compliance in the clinic's population," he says.

The project has a three-pronged approach that includes technology, culturally competent care, and community-based peer educators.

"Taking care of people with diabetes is complicated, and physicians have to remember an extensive list of things that need to be checked, including blood tests, eye exams, foot care. There's a huge laundry list, and it can't be done efficiently with a paper-based system. The team approach to caring for a patient with diabetes begins with the implementation of technology, he says.

The health plan funded a computer system that the clinic can use to implement the chronic care model for helping patients manage their diabetes.

"The model uses the team approach so that the moment a patient checks into the clinic, the staff is able to engage the patient immediately and start talking about what tests are needed and provide education. This allows the doctors to focus on specific aspects of care," he adds.

The health plan also is providing funding for the three-year pilot project that includes funds for a bilingual, bicultural health educator to work with the diabetic population.

"A key to compliance is having someone who not only speaks the language but who is culturally competent as well. It's not enough to translate the treatment plan into Spanish. There has to be someone who understand the culture and who can provide culturally competent counseling with

individual patients," he says.

In addition to working with diabetics one-on-one, the health educator is using group counseling, a highly effective and efficient way for people to learn from each other, he adds.

The health educator has developed a curriculum for the third phase of the program — the use of lay health workers, called promotores, or health promoters, who will work with the most challenging patients in their home.

"This model has been very successful in other countries, and we think it will work well here. The promotores will visit the homes once a month and work with people who are having problems with compliance. This is a wonderful way to break down the barriers of mistrust that occur by having a peer reinforce the message of the clinic," he says.

The clinic recruited the promotores from among its patient population, looking for people who are well respected in the community. Many have some kind of background in health care in their native country but are not necessarily qualified as a health care professional in America.

The promotores were recruited and trained over the summer and made their first home visits in September, reporting their findings to the clinical staff, who will use the information to know where to focus on the patient's next visit.

"It's a comprehensive and focused program to meet the needs of the patient," he says.

The overall aim of the program is to increase the level of trust among clinicians and the immigrant population, ultimately resulting in changed behavior, Shematek points out.

"Disease management is about changing behavior. It is most effective when the education is done by someone who speaks the language, understands the culture, and generates a level of trust," he says.

For instance, since controlling diabetes largely depends on nutrition, diet, and exercise, the CareFirst program has the advantage of having someone doing the educating who is familiar with the types of food the Latino population enjoys. She can come up with recipes that the patients are likely to use, rather than steering them toward unfamiliar foods, he adds.

"There are a lot of issues around health beliefs that are culturally unique. For a disease management plan to be effective, it must be coordinated by someone who understand how health care is sought, to what extent it is sought, and how members of that particular population communicate with the physicians and nurses," he says.

Someone who is a peer and understands the culture can gain the patient's trust and find out why he or she may not be following the guidelines, he points out. ■

CM results in lower blood sugar, cholesterol levels

Program is tailored to meet individual goals, needs

A case management program for diabetes has resulted in a steady drop in hemoglobin A_{1C} levels and cholesterol levels among members of ConnectiCare, a regional HMO based in Farmington, CT.

The program was developed in 1998 to address the specific needs of adult members with a diagnosis of diabetes, according to **Lori Pennito**, RN, program coordinator for the heart and diabetes program at ConnectiCare.

The program follows the goals and guidelines of the American Diabetes Association and aims to improve the health outcomes and quality of life for members with diabetes, helping them learn to manage their disease.

The percentage of members whose A_{1C} levels indicate that diabetes is out of control has dropped from 37.5% in 2000 to 23.4% in 2005. At the same time, the percentage of members with diabetes with LDL cholesterol levels less than 130 mg/dl has improved from 36% in 1999 to 70.3% in 2005, the last year for which statistics are available.

ConnectiCare was one of the first HMOs in the nation to receive NCQA accreditation for its disease management program.

The health plan uses claims data to identify members with diabetes and laboratory data to identify those who are at highest risk.

Initially, case managers coordinated the care for all members with a hemoglobin A_{1C} of 9 or greater. Since the program began, overall A_{1C} levels have dropped to the point that the high-risk member outreach program targets members with a level of 8.5 and above.

When a member is identified as being at risk, a trained program assistant calls the member and introduces him or her to the program, following a script that includes several opportunities for the member to be warm-transferred to a nurse if the member wants more information on the program.

"Among the inherent challenges in any disease management program are getting in touch with the members and getting buy-in from them. It helps to have a brief introduction to the program, to verify the demographics, and to be able to transfer the call to the nurse case manager," Pennito says.

Using the program assistants to do the outbound calls was a process that evolved over time as the health plan looked for the best ways to engage members in the program, Pennito says.

Initially, the case managers were making the outbound calls, but they were spending too much time on the telephone trying to reach the member.

"It was not the best use of a professional's time," she adds.

When the health plan began using trained program assistants to do the outbound calls, enrollment in the program increased 23%.

When the program assistant locates a member, he or she introduces the program and either warm-transfers the member to a case manager or sets a time for a call from a case manager in a day or two.

The case manager conducts an intake assessment that includes an overall picture of the member's state of health, his or her knowledge of the disease, and how he or she is trying to keep it under control.

"The case managers spend a lot of time building relationships and getting an idea of the member's overall knowledge of the disease and what they should be doing," Pennito explains.

The case manager typically will arrange to call the member within a week or so to follow up.

"Case management is more intense in the beginning for several reasons. We want to make the member feel like they are a part of the program, and we have found that it is more effective to break up the educational component into smaller pieces so we don't keep the members on the telephone for long periods of time. The follow-up calls also reinforce the teaching," she says.

The case managers in the program are specifically trained in managing the care of diabetics. They do not use a script but proceed the way they feel will work best with each individual member.

"The plan is based on the nurse's expertise and what the member is willing to do," she says.

The case managers have a frank discussion with the members about the severity of the illness and what can happen if it isn't under control, she adds. They follow up on laboratory tests and other data.

"We are looking for objective data that the members are making some lifestyle changes, such as more desirable results from blood tests," she says.

How often a case manager makes follow-up calls depends on the members, what issues they are struggling with, and what goals they are trying to reach. It may be monthly, quarterly, or more frequently, depending on each individual's needs.

For instance, if they are trying to modify their diet, the case manager may call them frequently to make sure they are doing so, she says.

Members stay in the program until they decide to opt out or the case manager feels they have exhausted the benefits of the program.

One of the key goals of the program is to reinforce the physician's plan of care. The case manager does an assessment of what the doctor has prescribed, including medication, self-monitoring of blood sugar, diet, and exercise.

"They get a feel for what the members are actually doing and reinforce what the doctor has told them to do," she says.

The case managers are on the lookout for gaps in care and alert the member's primary care physician when recommended treatment regimes or tests have not taken place.

"Depending on what the issue is, the case managers will write or call the physician, highlighting the gaps in care, based on evidence-based guidelines," she says.

ConnectiCare sends out a quarterly report to physicians that includes laboratory reports on lipid levels and blood sugar levels.

If a member has a hemoglobin A_{1C} level of 7 or more or an LDL cholesterol level of 100 or higher, the primary care physician gets an individual report. ■

DM program cuts overall health care costs by 10%

Plan focuses on pre-diabetics who are at risk

By engaging members who are at high risk for diabetes and getting them into a health management program before the disease creates problems, Blue Cross of California has reduced medical cost for members in its diabetes disease

management program by 10% overall.

"By the time someone has symptoms, they already have the disease state and are much further along than we would like them to be. At Blue Cross of California, we're tying to identify the pre-diabetics and engage them," says **Anthony Nguyen**, MD, MBA, FACHE, medical director for the health plan, a subsidiary of WellPoint Inc. with headquarters in Thousand Oaks, CA.

The company's disease management programs are instituted through the Health Management Corporation, a wholly owned subsidiary of WellPoint.

The health plan has seen a return on investment of $2.48 for every $1 spent on its disease management programs overall.

The diabetes program has shown a 4% reduction in the cost treatment at inpatient facilities, a 6% drop in outpatient costs, a 20% reduction in emergency department visits, and 10% overall savings in medical costs.

The health plans uses health care informatics, including claims data, pharmacy data, and laboratory results, to identify people who are at high risk, such as people whose laboratory values show that they have borderline diabetes and high cholesterol.

To keep a handle on people who may be in danger of an exacerbation, the health plan stratifies members on a monthly basis.

"A member may not be at high risk today; but in a few months, something could happen that puts them at risk. We don't wait until the end of the year to stratify the members," Nguyen says.

Members who have been identified as being at high risk for diabetes and its complications receive outreach calls from behaviorists, people with medical backgrounds who are trained in behavior modification techniques.

"The behaviorists try to sell the program to the member, telling them that their employer has purchased the benefit and how it can help them. They also engage in behavior modification during the initial call, which makes our program unique. It doesn't matter how many people you identify for a program; if you can't get an individual to change his or her behavior, the end results will never be achieved," Nguyen says.

By using behaviorists to make the initial phone calls, the health plan has achieved an 83% enrollment rate in all five disease states.

"Unless you can sell and engage a member, you aren't going to be able to get them to go along with the rest of the program," Nguyen says.

The behaviorists talk about how diabetes is a silent killer, and that by the time the member notices eye problems or difficulty in urinating, it's late in the game.

"We don't use scare tactics but use an educational engagement process to help the member see the benefits of the program his or her employer has paid for," he says.

The behaviorists turn the member over to disease management nurses with training in diabetes management.

The members receive phone calls with help tailored to their individual needs and a frequency that is based on their stratification.

"We individualize the program as much as possible because each member is a unique person with unique needs," he says.

For instance, one diabetic may have foot problems and need to quit smoking, while another may have difficulty administering daily insulin shots.

Disease management with a team approach

At Blue Cross of California, disease management is a team approach, with the disease management nurse serving as quarterback for the team.

"The nurses can call in a dietitian for help with meal planning or a social worker who can suggest community resources. They keep the patient's physician in the loop as part of the team," he says.

Once a member has agreed to join the program, his or her primary care physician is alerted and receives regular updates from the disease management team.

The disease managers help the members gradually meet their health care goals and work with them depending on the disease state and the level of engagement the member wants.

For instance, if a member has just been told he needs to quit smoking, lose weight, take insulin, and get his blood pressure under control, he is likely to be overwhelmed by the magnitude of the changes he needs to make.

"We encourage them to take small steps that can add up over time," Nguyen says.

The disease management nurses tailor their interventions to the way the member wants to communicate. Some prefer e-mail. Other would rather receive a phone call.

Members who have moderate risk receive a telephone call, an introductory letter, and a disease management kit that they are encouraged to

share with family members.

"We know that the diabetic's spouse may be cooking for them, and we want to encourage other family members to get their parent to follow the diet or take walks," Nguyen says.

In addition to printed materials that are mailed to them, members have access to diabetes management information on the health plan's web site and may call the health plan's nurse advice line 24 hours a day.

The health plan uses a multilingual staff to communicate with the members.

"We have staff who understand the cultures and languages of our members and who are sensitive to cultural beliefs that could affect their compliance with the treatment plan," Nguyen says.

The disease management nurses and the staff for the nurse advice line work out of call centers located in several parts of the country. The call center staff have the ability to warm-transfer members to someone at another center if that is what it takes to find a nurse who speaks the member's language.

"Each person is different, and many of our members are from different cultures. It is helpful to have a nurse who speaks in their individual dialect and who understands their culture," he says. ■

Study: Homeless HIV patients benefit from CM

ART adherence, CD4 cell counts improved

San Francisco investigators have found that case management as part of HIV medical treatment is associated with better adherence to antiretroviral therapy (ART) among people who are homeless or marginally housed.

"Case management also was associated with greater improvement in CD4 cell count, and it was associated with improved health outcomes among HIV-positive people," says **Grant Colfax**, MD, co-director of the HIV/AIDS statistics, epidemiology, and intervention research section of the San Francisco Department of Public Health in San Francisco.

"It's not a causal relationship, and we can't say it's causal because this was not a randomized study," he notes. "We looked at homeless people and compared those who were marginally housed or homeless, and we looked at whether they had a case manager or not."

Investigators defined case manager loosely, including those with professional degrees and those with training, but less formal education.

"We didn't distinguish in our study between nurse case managers or peer counselors or other types," says **Margo Kushel**, MD, an assistant professor of medicine at the University of California, San Francisco and San Francisco General Hospital.

"We included case managers who offered some services themselves, including counseling, and we included others who operated more in a brokerage model in which they made sure the client got to the proper services," she explains.

When a participant indicated receiving case management services, investigators confirmed this by interviewing the case manager, Kushel says.

The case management programs were operated by a variety of different organizations, Colfax notes.

"We looked at what was the impact of case management as it is currently in the community on these outcomes, and we looked at whether people reported having a case manager or not and then compared the outcomes to those who didn't," he says. "We didn't do anything to the case management programs."

Case management services were divided according to the frequency of use: people who saw a case manager in less than 25% of the study's five quarters were grouped with people who reported receiving no case management services. About 41% of study participants fell into this category, she says.

Clients who saw a case manager between 25% and 75% of the quarters were grouped together as receiving moderate case management, Kushel adds.

About 24% of clients reported receiving moderate case management services, she says.

The category of consistent case management included people who had received case management in 75%-100% of the five quarters, and 35% of participants were in this group, Kushel says.

"We saw that in terms of adherence, there was very little difference between moderate and consistent case management," she explains. "With the CD4 cell count, it did look like people with consistent case management did better than those with moderate case management and those with none, but for virological outcomes, it was pretty

much the same thing."

Investigators accounted for a number of factors, including gender, race, ethnicity, age, drug use, etc., Colfax says.

"We still found that case management was associated with a better outcome," he adds. "It's hard to do a study where you randomize to case management or not, so it's an important outcome that people in our system who had case management had better outcomes than those who didn't."

There appeared to be no difference in consistent primary care services or emergency room visits between the groups of clients who received moderate or consistent case management and those who received little or none, Kushel says. "Everyone had high rates of regular primary care, so it was hard to improve on that."

Adherence was measured according to both missed pills and CD4 cell count, she notes.

Those who had good adherence also were more likely to have an undetectable viral load of less than 400, Kushel says.

Case management was not independently associated with improved viral load, however, she adds.

Nonetheless, the results are encouraging, Kushel says.

"This was exciting to us because it hasn't been shown before that having a case manager helped with adherence," Kushel says. "Although, it certainly makes a lot of sense because this population is poor, homeless, has substance abuse problems, and perhaps case managers were helping people get to doctor appointments, take their medications, help with side effects, and help with medications refilled."

What the research doesn't show is whether one type of case management provides more benefits than another type, Kushel notes.

"It's possible some worked better than others," she adds. "If one form of case management is better than others, then we should base our resources on it."

The agencies included in the study were promised anonymity, but Kushel found that the case management programs were generally impressive.

"We were impressed with the dedication and resourcefulness of the case managers we met in the systems, but I wouldn't say that one model stood out over another one," Kushel says.

"The bottom line is this study supports the need for case management in this marginalized and homeless population because it showed improvements in health outcomes," Colfax says. "We had hoped that was the case, but now we've looked at it here, and we've found strong evidence that this was the case." ■

Patients at this hospital have a 'ticket to ride'

Handoff problem addressed with form

A new program at Doctors Hospital in Coral Gables, FL, helps move patients seamlessly from one department or unit to another, helping address the challenging issue of handoffs. Patients get a "ticket to ride" whenever they leave their hospital room — be it a transfer to another unit or a round trip down the hall for an X-ray. With checklists for tests, procedures, and nurse's observations, the new peach-colored form helps relay patients between staffers.

Pat Blanco, RN, MPH, CHE, CPHRM, the risk manager at Doctors, first learned of this approach on the National Patient Safety Foundation listserv. "Someone mentioned they were using it, or planning to use it," she recalls.

Blanco felt such a vehicle was important because "patients are handed off so many times throughout the day without a real opportunity to give information and ask and have questions answered."

The classic example, she says, would be a patient going to radiology who is a fall risk — but that information has not been communicated to the technician. "So the tech takes the X-ray, leaves the patient on the table, and comes back and finds the patient on the floor," Blanco suggests.

The technician, she explains, "Will not go through a four-inch chart to find this information. Nurses have a Cardex, and so forth, but when a patient is handed off, what really is needed is that opportunity to give information." The fact that this is one of the Joint Commission's National Patient Safety Goals, she notes, was naturally an important driver in the initiative.

Committee creates forms

Blanco put together a handoff committee, which started to meet in the fall of 2005. She jointly chaired the committee with the manager

of one of the patient care units. The members of the committee were nurse clinicians from each unit and other parties Blanco felt had an interest in handoffs — i.e., the managers of radiology and respiratory therapy.

"We met about every two weeks," recalls Blanco. Using the PDCA (plan, do, check, act) rapid cycle approach, "We added a certain set of items, tried the ticket, then after two weeks clinicians would come back and say they needed some more information on the form or that some step was cumbersome and needed to be taken out."

At one point, for example, the committee felt it was important to note whether a patient was a monitor patient. "In the next cycle, it was added, but we noted that when we take the patient out of 'tele' to go somewhere else, you want to call the monitor tech to tell them they were leaving the floor."

The form kept growing, says Blanco. "At first, to indicate precautions, we would just check them off," she says. "Then, next to the box, we would put 'aspiration,' 'bleeding total hip,' or 'knee,' so we knew what kinds of precautions were needed."

It's still a short list, says Blanco, although it is more complete than it was. "We've met many times since the last change, and we have not had any need to add or subtract anything," she notes.

Blanco said she did not need to seek formal approval to institute the new system. "The director of nursing periodically attended our committee meetings and could have said something if she was opposed," she notes. "Since she didn't, we assumed we had nursing's approval."

In addition, the committee took the form "everywhere" — i.e., to a whole series of committees, including QI, as an informational measure.

How the form works

Blanco explains how the "ticket" works in practice. "If a patient needs to go to radiology, the floor calls and says, 'Bring down Mrs. Smith in Room 3427, and call transportation.' Transportation takes the ticket to the floor, finds the patient's nurse, and then fills out the ticket."

The nurse signs the form and the transporter signs the form. (Below the section where the nurse signs the form is a place for comments.) The nurse signs both her name and phone number, so if a radiology tech gets the ticket and does not understand something, he knows exactly who to call. "That's part of the National Patient Safety Goal — to have the opportunity to ask questions and to have those questions answered," Blanco notes.

When the patient leaves radiology and goes back to the room, there is a section for the tech to make comments — such as, "IV infiltrated," or "We could not do the test because the patient was too nervous."

The tech signs his or her name and the transporter signs it again and then sends it back with the patient. The nurse who receives the patient has to sign it again, because the ticket goes back to transportation.

The ticket is used "whenever a patient travels," says Blanco. It's good from midnight to midnight. If a patient travels a second time during the 24-hour period, on the next trip there is a place for the nurse to put additional comments, and the transporters bring back the same ticket.

The earliest version of the ticket was used last November. As of this March, the staff started using the current version.

Positive staff reaction

The staff reaction has been very positive, Blanco says. "They realize its importance," she says. "Transportation knows they can't move a patient without a ticket. Even if a nurse did not want to use it, they would have to do so, but they realize there is a lot of information that should be communicated on some patients when they leave the floor."

The transporters, she continues, have been made to feel they are an important part of the team. "They are not just regarded as robots; they take responsibility for the patients, and they have been made to feel like they are important," Blanco observes.

It is far too early for quantitative proof the ticket has improved safety, "But qualitatively, the nurses feel like if they are sending someone with critical information, it will be readily available to the receiver — and those receivers say they truly appreciate that, when they receive that patient, they have that information. They know if the patient is combative, if they are a falls risk, or if they need a specific amount of oxygen," she says.

Since the receivers have to sign the paper as soon as they have received the patient, "This means they must do an immediate review of the patient," Blanco summarizes. ■

Leapfrog Group, NJ Blues start recognition program

Hospitals to be given choice of two programs

Horizon Blue Cross Blue Shield of New Jersey (BCBSNJ), headquartered in Newark, in collaboration with The Leapfrog Group, in Washington, DC, has launched the Horizon BCBSNJ Hospital Recognition Program, offering New Jersey hospitals financial and public recognition for high-quality and effective hospital care.

Horizon BCBSNJ, reportedly the first health plan in the nation to implement a statewide hospital recognition program in collaboration with The Leapfrog Group, will offer all of its network hospitals the option of participating either in a program based on the Leapfrog Hospital Rewards Program or in a similar program created by Horizon BCBSNJ.

The Leapfrog program provides a nationally standardized methodology to assess the value of patient care by measuring performance along two dimensions — the quality of the care hospitals provide, and how effectively they deliver it. Its methodology utilizes standardized performance measures developed by the Joint Commission on Accreditation of Healthcare Organizations, the Centers for Medicare & Medicaid Services (CMS), and Leapfrog itself.

However, says **William Finck**, MBA, the director of physician and ancillary networks at Horizon BCBSNJ, "We recognized that there is a cost to participation in the Leapfrog program, and we did not want to force hospitals to incur a cost in order to participate."

Horizon already had its own recognition program, which included the reporting of compliance with the Joint Commission's National Patient Safety Goals and CMS' 20 core measures for disease states. "We added compliance with the IHI's 100,000 Lives campaign and some patient satisfaction and administrative measures," says Finck.

"We aim to catalyze change, and in Horizon we've found a willing partner," adds **Suzanne Delbanco**, PhD, chief executive officer of The Leapfrog Group. "The significance of this partnership is that we are working together from the 'buy' side of the market to create a more sustainable and more potent pay-for-performance program than most of what's out there."

Part of the innovation that comes with Hospital Rewards, she continues, is that it is not entirely based on purchasers or payers needing to put all 'new' money on table. "It's not like new funds have to be found to create incentives or rewards," she explains. "Instead, much of it is paid out from the savings that occur as the hospitals improve. That's a shift from what the typical pay-for-performance program is designed to do."

Recognizing improvement

Horizon BCBSNJ had been producing its report based on CMS core measures and JCAHO safety goals for the past two years, Finck relates. "Internally, we were trying to determine whether it was having any effect," he shares. "What we were delivering to the individuals hospitals was, 'Here's how you compare to the network.' We felt we should develop some form of recognition to go along with the reporting."

As they looked around, Horizon ended up with Leapfrog. "In the areas of heart attack/aspirin on arrival and discharge and how much more important one was versus the other, Leapfrog had done some actuarial work," he explains. "In addition, from the perspective of hospital participants, this would no longer be 'Horizon's program.' These are nationally valid measurements, actuarially proven, that show improvements in outcome based on financial and public recognition."

"What this means is that when we looked for what clinical areas to focus on, we wanted to choose not only areas where there were clinical shortfalls, but also where we knew there was potential for significant improvement," Delbanco explains.

"We knew, for example, that LOS and readmission rates for these areas had that potential. When we see a lot of variation in LOS, it means that some hospitals have to figure out how to do it better and more efficiently use their resources. So, actuarially, we looked very carefully at the data in areas where we knew there were opportunities for reducing LOS and readmission rates," she says.

Clinical areas

Leapfrog has chosen five clinical areas (coronary artery bypass graft, community acquired pneumonia, percutaneous coronary intervention, acute myocardial infarction, and deliveries and newborn care) "that are significant to the private sector — either because their performance tends to change tremendously — with some hospitals

performing below what we know is possible — and/or because they are known to be expensive," Delbanco observes. "By highlighting the importance of improving in these areas and creating an environment more conducive to improvement, we will see a lot of unnecessary waste being reduced."

Actuaries at Towers Perrin analyzed hospital quality and payment data to identify these areas. These five areas represent approximately 33% of admissions and 20% of inpatient expenditures for commercial payers and present significant opportunities for improvement. To measure the efficiency of resource use, Leapfrog examines severity-adjusted average length of stay and readmission rates for each of the five clinical areas.

Another thing that's unique about the program, Delbanco says, is that "It's one of the first to use efficiency measures; we will look directly at resource use. And, it's a completely open methodology, which, I would argue, is meaningful to patients. If someone wants to get care, the last thing they want to do, for example, is go to a hospital with a high readmission rate," Delbanco says.

Open evaluation process

The evaluation process itself likewise will be transparent. "Hospitals currently report to their core measure vendor for the Joint Commission and CMS," Finck notes. "The core measure vendor then sends it to Leapfrog's data aggregator — Thomson Medstat — which runs the data and returns the results. The hospital can question the results if they wish, and nothing is finalized until the hospital agrees with the data."

The hospitals then are ranked in Levels I through IV, in increments of 25%.

"The maximum a hospital can earn is between $100,000 and $200,000," says Finck. In addition, he notes, the rankings will be put on Horizon's web site. "We will report twice a year and recognize facilities once a year," he says.

Finck is convinced the program will help improve quality. "We think it will, because in order to get recognition you have to have improved your performance standard; you have to move from the current level to next," he says, adding that a hospital that is already in the top tier will be recognized if it remains there.

"But if you improve more than 10% from the previous report period, we want to say 'thank you,' and let people know what you've accomplished," he says.

(Leapfrog estimates that potential savings due to lives saved and avoided readmissions for six types of admissions for the entire Horizon patient population could amount to as much as $138 million.)

"We think that because of Leapfrog's vetting of performance standards, plus the efficiency resource component, this is a good, strong program," Finck adds. "Payers and their hospitals are not always the best of friends; during negotiations, especially, they can get antagonistic. We're trying to take that [antagonism] away."

Leapfrog is looking to establish similar partnerships in other states — and with other payers and purchasers as well, says Delbanco. "The initiative does not have to be statewide; we already have a lot of movement in the Memphis marketplace, and we are also working with a couple of national health care insurance carriers," she shares. ■

Louisiana to redesign health care system

The state of Louisiana has unveiled a new public-private collaborative that will redesign its health care system in response to the impact of Hurricane Katrina. The collaborative hopes to fund its efforts through a proposed large-scale Medicaid waiver and Medicare demonstration program.

Called the Louisiana Health Care Redesign Collaborative, it plans to submit its proposal to the federal government by October, focusing initially

COMING IN FUTURE MONTHS

- How to know when a client is ready to change
- How health plans are improving outcomes for diabetics
- Face-to-face case management for seniors pays off
- How one health plan consolidated its care management services

on the greater New Orleans area. Its charter outlines guiding principles and its goal of a health care system that offers high-quality, accessible, patient-centered care, delivered by ambulatory and community-based centers. **John Matessino**, president and CEO of the Louisiana Hospital Association and a collaborative member, called the effort "a wonderful opportunity to change some of the ways things have been done" in the state. He said the group is particularly eager to target New Orleans' soaring rates of uninsured residents and to find them medical homes. ■

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 **December** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

CE questions

13. According to the Centers for Disease Control and Prevention direct medical costs from diabetes totaled what dollar amount in 2002?
    A. $40 billion
    B. $67 billion
    C. $92 billion
    D. $132 billion

14. CareFirst BlueCross Blue Shield's diabetes disease management program includes lay health workers called promotores.
    A. True
    B. False

15. When ConnectiCare began using trained program assistants to do outbound calls, enrollment in its case management program for diabetes increased by what percentage?
    A. 15%
    B. 23%
    C. 27%
    D. 32%

16. San Francisco investigators found that homeless HIV patients who received case management had a greater improvement in which measure(s)?
    A. CD4 cell count
    B. Health outcomes
    C. Fewer adverse events
    D. Both A and B

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

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. ■