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

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IN THIS ISSUE

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Spread the word about the impact case managers have on patients, families

Keep business focus but keep in mind your influence on people

As the emphasis has shifted toward the business aspects of health care, some case managers also have shifted their focus from the positive influence they have on patients lives to the impact of case management on the bottom line, **Peter Moran**, RN, C, BSN, MS, CCM, asserts.

Recently elected the 17th president of the Case Management Society of America (CMSA), Moran, an emergency room case manager at Massachusetts General Hospital, wants to shift the focus so it is more balanced between the business case for case managers and how case managers help patients and families in difficult and stressful situations.

Moran is the first staff case manager and the first hospital-based case manager to serve as president of CMSA, an international organization with headquarters in Little Rock, AR, representing more than 10,000 members who work in the case management field.

"When I started out as a case manager, case managers were focused on the patients and how we could help them. Over time, that has been considered a nicety but there has been more of an emphasis on return on investment. As we struggle about how to justify case management, more case managers are thinking with their business hats on," he says.

Case managers still have to make a case for the business aspects of case management but they need to start emphasizing how they impact patients as well as family members, he adds.

"I understand about business and return on investment, but I never forget in my daily practice that my reason for being a case manager is that I believe I can impact outcomes and improve lives," Moran says.

When case management directors talk to the CFO about instituting new programs, they need to be able to show the return on investment that case management initiatives bring about but they should balance it with anecdotal information about how case managers positively impact

patient-centered care, he adds.

"It's not all about the money. We can have a good return on investment by meeting patients' needs. I never speak before any audience without giving a patient story. As we tell the stories of how we have helped patients, it brings us back to reality that although we are in a business, we are also dealing with people," he says.

Case managers 'have arrived'

Today's case managers face challenges but also new opportunities in the rapidly changing health care environment, Moran says. "Health care is truly at a pivotal point in history and case managers are uniquely positioned to positively impact the health care system and the clients we serve. Case managers are no longer the best kept secret in health care. We have arrived and we need to embrace the spotlight and the opportunities presented to us so we can continue to improve the care we give," he says.

As president, Moran plans to reopen the CMSA standards of practice for review and updating.

"Case management is evolving and we need to develop a new paradigm with fewer silos and more collaboration across disciplines. In the past, different disciplines have worked in their own silos but everybody has a vested interest in the patient's outcome. In order for us to make progress, every discipline working at every level of care, must work together," he says.

CMSA has helped organize the National Transition of Care Coalition and is collaborating with other health care stakeholders on the panel to develop ways to eliminate some of the problems that occur as patients move through the continuum of care.

"The multidisciplinary players at the table — nursing, physicians, pharmacy, case managers — are working with representatives from business coalitions and citizens groups as well as organizations like URAC, The Joint Commission, and the Centers for Medicare & Medicaid Services [CMS]. The various parties are looking to be collaborative in this effort. The coalition is not breaking down into turf wars. We are seeing a problem and how we can address it," he says.

The initiatives created by the coalition will be helpful to case managers as they struggle with providing continuity of care across the various venues of care in the health care system, he adds.

Caseload calculator

A joint work group from CMSA and the National Association of Social Workers (NASW) has introduced the first draft of a case management caseload calculator as the first step in developing a matrix to determine appropriate case loads for case managers in a variety of settings.

"Caseloads are a problem that every case manager struggles with daily. The Caseload Work Group was created to establish guidelines that case managers and social workers can use to help determine what their caseloads should be. This may not be the final answer but it's a step in the right direction," he says.

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Editorial Questions

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The caseload calculator is posted on the CMSA and NASW web sites with a public comment period that ended Sept. 17.

CMSA has another task force looking at the potential for expanding the practice of reimbursing physicians for medication adherence to other disciplines, Moran adds.

"Currently, physicians may get reimbursed for counseling a patient on medication and working on medication adherence with patients but other providers cannot. Many case managers work with patients on medication adherence as part of their care coordination routine. We are looking at ways to get that reimbursed," he says.

CMSA already has published case management adherence guidelines that case managers can follow to help their patients adhere to medication regimens and treatment plans, Moran points out. In addition, the organization has expanded those guidelines and included disease-specific guidelines for diabetes, deep vein thrombosis, and cardiometabolic risk, with several others under development, Moran says. The guidelines are available in English, Spanish, French, and Korean and can be downloaded for free from the CMSA web site.

Adherence 'new buzzword'

"Adherence is a new buzzword and the emphasis on it is going to grow by leaps and bounds," Moran says.

The emphasis on medication adherence and following evidence-based treatment plans gives case managers opportunities to expand the ways they improve patients' lives and at the same time challenges them to obtain new skills, Moran says.

"Medication reconciliation, although it is difficult to achieve within the hospital setting and in provider settings, is one practice that can only improve patient care as it cuts down on mistakes," he says.

New skill sets will be required of case managers in the future, Moran points out.

"We're starting to see it in some programs now. Case managers need to know how to make a health literacy assessment and medication knowledge assessment of patients. They need to know how to assess a patient's readiness to change and need motivational interviewing skills," Moran says.

Case managers across the spectrum of care already are working to motivate people to take responsibility for their own health practices, Moran points out.

"Hospital-based case managers have to address people who are hospitalized over and over for the same condition. On the payer side, there's a financial incentive to help people manage their health," Moran points out.

Community-based physician practices, especially those with a capitation-type model for reimbursement, also have an incentive to get patients to improve adherence to the treatment plan, he adds.

"For patients to follow plans of care based on evidence-based best practices can only serve to improve their health and the health of the nation. Facilitating the flow of information will serve to decrease unnecessary and expensive duplicate services and expedite a return to health," he says.

Moran challenges case managers to raise the bar and refuse to settle for the status quo and to find balance between the art and the business of case management; between their work and families; and between their work and finding the time to take care of themselves, he adds.

"It's an exciting time to be a case manager with many challenges and opportunities before us. We can both hide our head in the sand and try to maintain the status quo or we can move forward, embrace change, and grow and evolve to the next level," he says. ■

Telephonic, face-to-face interventions help seniors

Special Needs plan focuses on four chronic diseases

Chronically ill Medicare beneficiaries are learning to keep their disease under control through Care Improvement Plus's "Special Needs" Medicare Advantage plan that includes telephonic disease management and face-to-face meetings with a nurse case manager.

The program provides individual disease management and case management for seniors in Maryland, Georgia, South Carolina, Missouri, Arkansas, and Texas, who have diabetes, heart failure, chronic obstructive pulmonary disease, and/or end-stage renal disease.

Medicare beneficiaries with one or more of those chronic illnesses are eligible to enroll in the program, says **Harry Leider**, MD, MBA, chief medical officer for XLHealth, the parent company

of Care Improvement Plus.

"The big difference in this vs. a traditional Medicare Advantage plan is that in addition to covering hospitals, doctors, and other services, this plan is created around the chronic diseases," Leider says.

The plan's pharmacy benefit was designed around the four chronic diseases and includes a formulary specifically chosen for the diseases. For instance, members have lower copays for certain drugs used to treat the chronic diseases. The program's pharmacy benefit covers certain medications through the Medicare Part D "donut hole," the gap where most Medicare Part D benefits require beneficiaries to cover the cost of their medication.

"We want our members to continue to take their medicine and stay healthy," Leider says.

Every member in the plan is assigned to two nurses. One is a telephonic health coach who helps the members learn to manage their care and educates them about their disease.

The other is a local field nurse who works with the members face to face at Care Improvement Plus screening centers located throughout the community, or, if necessary, in the members' homes.

Care Improvement Plus started its Special Needs plan in 2006 with a smaller service area of just eight counties in Maryland. Since the plan was expanded into additional states and counties in 2007, enrollment has grown to more than 60,000 and is growing rapidly, Leider says.

Most of the members in the plan have more than one chronic condition, says **Cliff Madden**, RN, program manager of disease management at the Baltimore screening center.

The case managers, the disease managers, and the telephonic health coaches all work from the same computer platform and can share information on members if needed.

"We believe that the case management and disease management functions are better embedded in the community. Nurses who live in the community know the local resources and can help provide beneficiaries with the local support they need," Leider says.

The health plan leases office space in shopping centers and other locations in areas where there is a concentration of members. The screening centers are located near public transportation and on one level so the beneficiaries don't have to climb stairs when they visit.

When beneficiaries enroll in the plan, a non-clinical person in the Baltimore call center calls them and welcomes them to the program. Then they get a call from a nurse who administers a health risk assessment. The nurse gathers information using a computerized program that structures the questions according to the member's diseases and responses. She collects information about the member's hospitalizations, medications, the names of their physician, psycho-social or caregiver issues, and completes a screening for depression.

The health risk assessment stratifies the member's level of severity and determines whether he or she is appropriate for a disease management program or needs a more intensive case management program. Members receive regular coaching calls from the call center nurses at a frequency that is dictated by their risk score. The field nurses try to get all members in at least yearly for a face-to-face visit.

"Case management tends to be for the more complex patient with multiple problems. These are high-cost individuals with psycho-social issues who need a custom plan," Leider says.

For instance, if a beneficiary is a diabetic who has had a stroke, been hospitalized frequently, has family financial problems, and is being treated for depression, he or she would be placed in the case management program.

On the other hand, a member with heart failure who is taking an ACE inhibitor and a beta-blocker and is watching his diet and salt intake and weighing himself daily may be more appropriate to be monitored by a disease management nurse who works with the physician to prevent complications by following well-established evidence-based plans of care.

Members with higher risk scores receive more frequent telephone calls and are strongly encouraged to see the local field nurse for a face-to-face visit.

Those at a lower risk also get telephone calls and educational materials in the mail and are asked to come in to the screening center once a year, Madden says.

If the member lives in an area served by a screening center, the nurse transfers the member to the screening center's secretary who sets up an appointment for a face-to-face visit, Madden says.

"If they can't come in or we determine right away that they have an immediate need, like an open wound, we go out to see them in their home. We have a good compliance rate for get-

ting members into the center," Madden says.

If the members don't have transportation to the center, the health plan offers options with a transportation benefit that provides 30 one-way trips for doctor visits or to come into the center, he adds.

Face-to-face visits are an effective way to spot problems and to improve communication with the beneficiaries, Leider points out. "It's difficult to cover health care issues on the telephone with someone with mild dementia or who has other cognitive problems or hearing loss," Leider points out.

Often the field nurses invite family members or caregivers to accompany the beneficiary to the center and collaborate on a care management plan.

The nurses at the local centers record the members' height and weight, blood pressure on both arms and ankles, and other vital signs, depending on the disease. For instance, nurses use a test to determine if diabetic members have peripheral artery disease and a vibration test to determine if there is sensation in the foot.

The sensory examination often helps diabetics who are in denial realize the serious nature of their disease, Madden says.

"First, we perform the vibration test on their hand and we can see the light go on when they don't feel it in their feet. They get a little more serious about compliance," he says.

Skin problems, wounds, or ulcers are a major complication for diabetics, Leider points out.

About 30% of patients with diabetes don't have sensation in their feet, he adds.

The nurses perform foot examinations on the diabetics and set up quarterly visits to a podiatrist who can manage any skin problems and help the member avoid hospitalization, Madden says. The plan covers six podiatry visits a year.

Members who fail either the peripheral artery disease test or the sensory test or who have ulcers or wounds are fitted with special diabetic shoes by a pedorthist whose office is next door to the Baltimore center, Madden says.

The plan provides diabetics with free glucometers, teaches them how to use them, and arranges for supplies to be delivered to the home.

The nurses encourage members with heart failure to weigh themselves daily, provide digital scales if necessary, and teach them about their disease.

Members with severe heart failure, who have been admitted to the hospital in the past year, may receive a remote monitoring device that plugs in to the telephone. The members weigh themselves on the machine and answer a series of questions that are transmitted electronically to the monitoring nurse.

If the member has problems, the nurse at the monitoring center contacts the physician directly and informs the Care Improvement Plus team as well.

"We work closely with those nurses. If a member hasn't weighed in a few days, they'll alert us and if we can't get them by telephone, we may go to the home," Madden says.

Since the program began, the nurses have discovered hypertension in a number of members. In these cases, they call the physician to make sure he or she is aware of the condition. Sometimes the physician talks directly to the members and changes medication on the spot, Madden says.

Medication reconciliation is a big part of the program. Members are asked to bring in all the medications and supplements they take.

"We want to see their medications so we can check for duplications and create a comprehensive list. When we go to their homes, we always ask if we can look in the medicine cabinet and refrigerator and see what they are taking," Madden says.

Madden encourages the members to make appointments to see their physician and follows up in a couple of weeks to make sure they have seen the doctor.

In some cases, he suggests that beneficiaries come back to the center for a follow-up visit.

"If we think they need to be seen again, we bring them back. We have tough cases that we see almost weekly. These are usually people with open wounds and we visit to follow up on the home health care treatment," Madden says.

The nurses call in social workers for assistance if the beneficiaries need community services, such as Meals on Wheels or financial assistance.

"We try very hard and do everything we can to get these patients on the right track," Madden says.

When one member kept forgetting to get his medications filled, Madden worked with the nurse practitioner at the dialysis unit who filled the medications for him every week.

The program started in January and it's too soon for Care Improvement Plus to have any outcomes information but the nurses in the field

report a lot of progress, Leider says.

"We see great victories with our clients. We have gotten people set up with medications they didn't have before and we've watched them improve. We're seeing a lot of good things happening with these members," Madden says.

He attributes part of the success to seeing members face to face and taking the time to work closely with them.

The average visit lasts about 45 minutes.

"The members really appreciate the time we take with them. Their doctor visits are fairly short. We take the time to make sure they learn what they need to know about their disease," he says. ■

Initiative raises awareness of Tdap recommendations

Health plan honored for working to reduce pertussis

A multi-pronged approach to improving immunization rates for members, particularly infants and adolescents, has earned recognition for Independence Blue Cross from the Pennsylvania Immunization Coalition (PAIC).

The Philadelphia-based health plan was honored with the PAIC Immunization Champion Award for its collaborative work with the Pennsylvania Department of Health to reduce the rising instance of pertussis.

"Immunization awareness is just one of the many ways we work to improve access to quality, affordable health care in the region, promote community wellness, and improve the health of our members," says **Esther J. Nash**, MD, senior medical director of population health and wellness at Independence Blue Cross.

The health plan has promoted immunizations for many years, updates the recommendations each year, and provides coverage for recommended immunizations across all managed lines of business, Nash adds.

"In recent years, there have been changes in the recommendations as well as new recommended vaccines that mean more visits to health care providers. The key issue is to assist the patients and doctors in keeping up with the increasing number and changing recommendations for vaccinations," she says.

Most recently, the health plan has partnered with the Philadelphia Department of Health to create awareness of the expanded recommendations for administering the Tdap vaccine (diphtheria, tetanus, and acellular pertussis).

Barbara Watson, MD, PhD, of the division of disease control at the Philadelphia Department of Health proposed a collaborative effort to combat the rising instance of pertussis (whooping cough) in the Philadelphia area.

"She was concerned about the number of cases in pertussis, particularly among adolescents and adults. We collaborated on ways to ensure compliance with the new recommendations for expanded use of Tdap," Nash says.

When the pertussis vaccine was developed in the 1940s, the number of cases of the disease dropped dramatically, according to **Donna Mulgrew**, RN, BSN, senior preventative health coordinator for Independence Blue Cross.

"Since the 1980s, the number of reported cases has been creeping up, particularly among adolescents and adults," she adds.

New recommendations call for adolescents between the ages of 11 and 18 to receive a single dose of Tdap, instead of the tetanus and diphtheria booster given in the past, and for adults to receive at least one booster, she says.

"We now recognize that the immunity to pertussis that people develop through their childhood vaccinations wears off in many people as they grow older. How long the immunity lasts cannot be predicted but it can wear off or get to such a low level that people could have pertussis as an adult," Mulgrew says.

Pertussis in adults is a prolonged illness with severe coughing over a long period of time, she adds.

"In the past, it was recommended that adults receive the diphtheria and tetanus booster every 10 years. Now, recommendations call for at least one of those boosters to be the Tdap vaccine," she adds.

Boosting the immunity of adults not only protects them from a lengthy illness, it also prevents them from transmitting the disease to infants with whom they come in contact, who are at serious risk for complications of the disease, she adds.

"Parents and grandparents of infants or adults who care for babies need good immunity to pertussis. Over 60% of infants who develop pertussis have to be hospitalized. The disease is fatal in a significant number of cases," Mulgrew says.

The health plan's educational efforts focused on pregnant women, adolescents and their parents, and health care providers, informing all three groups about new recommendations for the Tdap immunization.

"We are particularly proud of our immunization outreach for adolescents. We took a creative approach to engage this age group and it paid off," Nash says.

The company designed a special web site for adolescent members and offers the chance to win a reward if they receive the vaccination. Families with children in this age group receive regular mailings educating them on the importance of keeping their vaccinations up to date.

"There have been a lot of changes in recommendations for immunizations for adolescents. Now, it's recommended that all adolescents receive the Tdap booster and the meningitis vaccine and that female adolescents receive the human papillomavirus vaccine. It is preferable for adolescents to receive the Tdap booster between 11 and 12 and that's who we target in our mailings," Nash says.

Independence Blue Cross HEDIS data for 2007 show that 81% of adolescents received all necessary immunizations in 2006, which puts the company in the 90th percentile of all health plans.

The health plan's Baby Blueprints program sent out targeted mailings on immunizations to pregnant members, advising them to discuss their immunization status with their health care provider and to make sure that whoever would be in contact with their newborn had received the vaccine.

"Ideally, a woman should receive Tdap before becoming pregnant but if they were already pregnant, we recommended that they receive the vaccine immediately after delivery," Mulgrew says.

Information on the recommended immunizations for infants and their caregivers is provided on the health plan's web site, through telephone outreach and targeted mailings to pregnant women enrolled in the company's Baby Blueprints maternity education program.

Perinatal nurse case managers who work with members in the health plan's high-risk pregnancy program received specialized training on Tdap and educate their clients on the importance of that and other childhood vaccinations.

The health plan sent updates to providers through its *Clinical Update* magazine, alerting them to the national Advisory Committee on Immunization Practices (ACIP) recommendations for expanding the use of the Tdap vaccine.

In addition, the insurer encourages providers to participate in the Philadelphia Department of Health's KIDS Immunization Registry, an electronic database of pediatric immunizations for children residing in Philadelphia County. The health department uses the information to identify under-immunized children and target them for outreach. ■

Education on postpartum mood disorders needed

Information vital for society as a whole

Expectant mothers receive a lot of information over the course of their pregnancy and are sometimes inundated with things to remember. Yet one important message that needs to be stressed is that some may experience postpartum mood disorders that can adversely affect their mental health.

"It is helpful to keep the basic message pretty concise and then if a woman is having difficulty elaborate more at that point," says **Laurel R. Spence**, MS, PA-C, maternal and child health director for Baylor College of Medicine School of Allied Health Sciences physician assistant program in Houston.

What is the basic message? According to Spence, there are a couple of key points. First, postpartum disorders can happen to anyone, although there are some patients that are considered higher risk. Also, it is important to know that these disorders are medical illnesses, which respond well to treatment.

"There is such a stigma surrounding postpartum depression, we need to demystify it," explains Spence.

In addition, women should be prepared for some baby blues after they deliver. According to Mental Health America, based in Alexandria, VA, 80% of women experience them.

Baby blues are mood swings that are a result of high hormonal fluctuations and cause women to cry easily and experience a wide range of emotions, from sadness and frustration to happiness.

The mood swings last about two weeks, but if a woman has more dramatic symptoms or they linger beyond two weeks, she may be dealing

with a postpartum mood disorder, says Spence.

Postpartum disorders include depression, and in rare cases, psychosis. Postpartum depression has symptoms similar to clinical depression that may include fears, such as excessive preoccupation with the health of the baby, or intrusive thoughts of harming the baby. One main symptom of postpartum depression is an inability to sleep when the baby sleeps, whether day or night. Also the new mother may experience irritability and feel easily overwhelmed.

A woman who develops postpartum psychosis loses touch with reality, experiencing delusions and hallucinations.

While baby blues are common, less than 30% of women experience postpartum depression and about 1% of women are diagnosed with psychosis.

"The reason it is very important for women to recognize the symptoms of postpartum disorders is because the symptoms don't just affect them — they affect the baby and the bonding with the baby, they affect the immediate family and extended family. When members of our society are not functioning well, which is the case with postpartum mood disorders, then that affects everyone in our society in some way," says Spence, who experienced postpartum depression with the birth of her three children.

Good education dispels myths

Education about postpartum mood disorders should be included in classes for expectant parents, says Spence. Also, health care practitioners should discuss them with their patients and make sure resources are given that can be referred to later to help people identify symptoms and seek treatment. Women who experience a postpartum mood disorder, such as depression, need medical intervention, therapeutic intervention, and social support, says Spence.

Identifying and treating disorders is important because women who have had one occurrence of postpartum depression that is not treated are 50-70% more likely to have a second occurrence says Spence. With two or more occurrences of postpartum depression, chances of a reoccurrence are elevated to as high as 90%. "It is pretty much guaranteed it will happen again," says Spence.

The Texas legislature passed a bill in 2003 mandating that resources and references be given to women who deliver in a hospital or birthing center of a certain size. The legislation was a result of the Andrea Yates case. Yates, a Houston resident, drowned her five children following the birth of her daughter. She battled with depression and had episodes of psychosis.

Spence says women such as Yates who are at high risk for postpartum disorders can be identified. A family history of mood or psychiatric disorders or prior personal history are indicators of risk.

"If a woman has had depression in the past or if there is a history of bipolar disorder or something more pervasive and chronic, then hormonal changes may induce a more severe state in that woman," says Spence.

In addition, stressful situations such as relationship problems, marital discourse, death in the family, or a job loss can all act as triggers.

Spence says that having a baby is stressful physically and emotionally, even under the best circumstances. If a woman is at high risk for disorders, it is wise to have a postpartum plan in place with support people identified in advance, along with their duties, all of which have been agreed upon. With a plan, a woman in the middle of a crisis doesn't have to find family and friends who are willing to help.

According to Mental Health America, screening women to determine their risk for postpartum disorders and setting into place a social support system to include physicians, partners, friends, and coworkers can help prevent a crisis.

Spence says providing written materials, such as books, to women who have had problems with previous pregnancies or have a history of disorders helps them know they are not alone. Also, it gives them confidence that they can get through an episode with proper help and treatment.

A major barrier to education about postpartum disorders is the belief that new mothers should be in good spirits in all circumstances. The media reinforces the image of the happy mom and baby with smiling women giving their newborn a bottle or changing a diaper.

"In some ways, having a baby can be the best time of a woman's life, but also it can be the hardest time. Imagine a woman with a mood disorder who wants to enjoy her baby. That special time can be stolen away, especially if she does not get treatment," says Spence.

Several factors contribute to postpartum depression, according to Mental Health

America. Intense hormone fluctuation after giving birth is one factor. Also, a major event that coincides with childbirth can make a woman more susceptible, as well as life stresses such as increased demands at work.

Screening should be part of a woman's postpartum visit to her physician. Answers to simple questions, such as, "Do you sleep when the baby sleeps?" provide cues.

A society that is well educated is important as well so there is compassion and understanding. And it isn't always family members who notice a problem as they often are too close to be objective. It may be friends who notice when a new mom doesn't want them to come over to see the baby because she is too overwhelmed. That is not characteristic behavior of a new mom, explains Spence.

"One of the initiatives of the Mental Health Association in Houston is to educate both the public and health care professionals regarding postpartum mood disorders," says Spence.

(Editor's Note: Mental Health America also recommends that couples having a baby be given information on the Postpartum Support International web site. This site provides details on disorders and has an on-line list of support groups as well as chat and discussion boards. Web site: www.postpartum.net.) ■

Patient access has role in disease management

ID chronic cases upfront, consultant says

The great majority of U.S. health care dollars are spent supporting the chronically ill, yet the traditional focus of hospital care is on the "episode of illness," notes **Bob Whipple,** RNC, CCM, CCS, MHA, a Boston-based senior management consultant with ACS Healthcare Solutions.

"In other words, chronically ill patients get sick, go to the hospital, and are discharged without their [ongoing] medical needs being addressed," Whipple contends. "This results in multiple admissions."

Ten percent of the patients are using 90% of the health care resources, he adds. "Something has to be done to decrease the cost of becoming sick and then sicker."

Disease management — preventive, diagnostic, and therapeutic services for types of patients considered at risk — is widely considered to be a more cost-effective approach to care, Whipple says. The Disease Management Association of America (DMAA), he notes, defines disease management as "a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant."

Full-service disease management, the DMAA states, must have six components:

- population identification processes;
- evidence-based practice guidelines;
- collaborative practice models to include physician and support-services providers;
- patient self-management education;
- process and outcomes measurement, evaluation, and management;
- routine reporting/feedback loop including the patient, physician, health plan, ancillary providers, and practice profiling.

Key to moving forward with a disease management model, he says, is increased clinical awareness and expertise, not only on the treatment side, but throughout the revenue cycle.

Patient access staff have an important role to play in the effort, Whipple suggests. "Most hospitals are not able to really identify who those [chronically ill] patients are.

It's critical to find out who they are and treat them in a different way. That should start upfront with the possibility of admitters being able to identify these patients when they come through the door."

Diseases commonly considered to be under the domain of disease management include the following:

- congestive heart failure;
- asthma;
- cancer;

- coronary artery disease;
- chronic obstructive pulmonary disease;
- cystic fbrosis;
- depression;
- diabetes;
- HIV/AIDS;
- hypertension;
- lupus;
- multiple sclerosis.

"At a minimum, we need to learn to identify these patients on readmission," Whipple says. "It's as important as getting the correct address and phone number." That could mean instituting a different protocol, he notes, such as having a code to designate patients as "frequent flyers."

That information should be communicated as soon as possible to case management staff, Whipple adds, so an appropriate treatment and education plan can be put in place. What occurs more often than not in today's health care environment, he says, is that patients — including the chronically ill — go through the care process under whatever designation they came in, whether it is correct or not.

"Often what happens is the patient comes in, especially if he or she is a frequent flyer, sits in front of the registration person, and [the registrar] says, 'Any changes since the last time?' The patient says no, and [the employee] just automatically fills that in."

His experience doing assessments at all kinds of facilities — from 700-bed inner-city hospitals to 12-bed rural hospitals — has shown him that "admitters sometimes put patients on the floor that don't meet local medical review policies (LMRP)," Whipple says.

Physicians in the emergency department (ED) don't necessarily know anything about medical necessity, he points out, and residents in training at large teaching hospitals often want to admit a patient simply because many tests have been ordered on the person.

Adding clinical expertise to every part of the revenue cycle is one way to ensure that only patients who belong in the hospital are admitted, and that those who do need to be admitted receive the proper care, Whipple says. Someone in patient access, he adds, such as a preadmission coordinator, "needs to able to step in and say, 'This person doesn't meet medical necessity.'"

"If there is a strong person on the front end, reviewing every patient who goes to a bed, things are likely to be OK on the back end," he adds, but ideally there is also a clinical component in the billing area.

Whipple recalls a time earlier in his career when he was one of two registered nurses working in the billing department of a big-city hospital. "I was busy all day just answering questions. I remember thinking, 'If I wasn't here, the amount of money lost would be incredible.' We found mistakes all week long."

Case management deficiency cited

Medical research has created a growing body of evidence on the most effective protocols for treating chronic diseases, Whipple notes."However, reports by the Institute of Medicine and others have observed that a large gap often exists between such evidence-based treatment guidelines and current patterns of practice."

"The number of medical studies has grown tremendously in recent years, making it ever harder for physicians to keep up with the latest developments," he adds.

The case management model in place at most hospitals is not adequately addressing the needs of the chronically ill, Whipple contends. "There are lots of case managers and most are not certified. It's 'teach as you go.' There may be 15 or 20 case managers at a big hospital and not all have the same expertise."

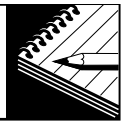
In many cases, "there is no way to ensure consistency, for example, on what they approve as inpatient or observation status," he says. "The big thing is having case managers in the ED. Some [facilities] have them, but they don't really know how to interact. They are floating between patients and the physicians don't know who they are, and sometimes resent them."

The best way to provide disease management in the hospital, Whipple says, is to have advanced practice nurses who round with physicians and are able to provide more interventions than a case manager.

"These nurse practitioners who round are actually involved with medical care, and determine whether a patient is compliant or not. They work with case managers to develop a discharge plan that really looks at the patient's needs."

(Editor's note: Bob Whipple can be reached at Bob.Whipple@acs-hcs.com.) ■

GUEST COLUMN



When are patients deemed 'unsafe' for home care?

By **Elizabeth E. Hogue**, Esq.
Burtonsville, MD

Discharge planners/case managers are likely to encounter instances in which home care, hospice, and home medical equipment (HME) providers state that they cannot accept patients because they are "unsafe" at home. The use of this term may be confusing to discharge planners/case managers. What is it about patients' homes that make them "unsafe" for them to receive services there? Aren't all patients appropriate for home care?

First, discharge planners/case managers may not have provided services in noninstitutional settings. If so, it may be difficult to make a crucial distinction between institutional care and home health services.

Specifically, in institutional settings the provider controls the "turf" on which care is rendered. In post-acute care at home, providers have very little control over the environment in which services are provided. In fact, patients control the "turf" in home care because services are rendered in their private residences over which patients have almost absolute control.

Consequently, home care providers often confront barriers to the provision of services that many discharge planners have not experienced. Staff have, for example, encountered "attack" geese when they arrive at patients' homes and risk the consequences of a serious "pecking" in order to reach patients' bedsides! Or, they have come eye to eye with a pet alligator named "Bubba" in a mobile home in Louisiana!

Although patients may not be adversely affected by pecking geese and may have a cozy relationship with "Bubba," there may be other factors over which home care providers have no control that clearly jeopardize the well-being or safety of patients. These factors may make it impossible for providers to render services at home.

Patients' homes may, for example, be in such disrepair that both patients and caregivers are at risk. A home health nurse, for example, recently fell through the floor of a patient's home as she approached the patient's bedside.

Patients' homes also may be infested with roaches, rodents, and/or vermin of various types and descriptions.

Patients may suffer repeated falls at home despite appropriate interventions from providers that make it risky or "unsafe" for patients to remain at home.

Despite these examples, discharge planners/case managers still may be unclear about why patients cannot be cared for at home when post-acute providers decline referrals on the basis that patients are "unsafe." It may be helpful for providers to be much more specific in their communications. Specifically, it may be more helpful for providers to say, "The patient's home environment will not support services at home for the following reasons . . ."

When providers' communications with discharge planners/case managers are vague or unclear, it may be helpful for discharge planners to prompt more specific communication by asking: "What are the specific reasons why this patient's home environment will not support home care services?"

Institutional care and home health services are fundamentally different models of care. Because the differences are so great, it is reasonable to expect that providers who practice primarily in institutions and those who work in home care may not always understand or account for important factors involved in different types of care. Clear, specific communications are, therefore, absolutely essential for the well-being of patients. ■

COMING IN FUTURE MONTHS

- Managing the care of chronically ill children
- Taking case management into the home
- How workplace wellness can pay off for you
- Ways to identify your clients' health care literacy

CE questions

13. A caseload calculator, developed by the Case Management Society of America and the National Association of Social Workers is a step in developing a matrix for determining work loads for case managers.
    A. True
    B. False

14. Care Improvement Plus's "Special Needs" Medicare Advantage plan covers seniors in which states?
    A. Georgia
    B. Massachusetts
    C. Maryland
    D. A & C

15. When the pertussis vaccine was developed in the 1940s, **Donna Mulgrew**, RN, BSN, senior preventative health coordinator for Independence Blue Cross, says the number of cases of the disease:
    A. dropped dramatically.
    B. increased dramatically.
    C. stayed the same.
    D. disappeared.

16. A common symptom of postpartum depression is that a new mom is able to sleep when the baby sleeps day or night.
    A. True
    B. False

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

CE objectives

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

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

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. ■