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

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IN THIS ISSUE

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CM program serves young Medicaid beneficiaries with complex needs

Program targets chronically ill members ages 6 months to 21

A multidisciplinary care management program for young Medicaid beneficiaries with complex conditions has resulted in significant increases in members' use of effective treatments and services.

In the first year of the program, administered by CareSource, the percentage of children using appropriate asthma medications rose from 50% to 57% and well child visits increased among all age groups, earning the health plan a rating of excellent from the Ohio Department of Job and Family Services.

The program started in 2001 in response to a new state requirement to promote case management for chronically ill children in the Medicaid population.

"As part of our mission to help the under-served population, CareSource has always offered case management services to its members but expanded the program to meet the state requirements. When the state specified providing case management for members ages 6 months to 21 years with special health care needs, we expanded the program in-house and hired case managers who specialize in conditions such as prenatal care and asthma management," says **Daniel Paquin**, COO of the Dayton, OH-based Medicaid managed health care plan.

The department includes asthma educators, diabetic educators, prenatal-care specialists, and behavioral health specialists.

"We have included case managers who are experienced in a variety of areas so we can provide the best possible care coordination for our members," Paquin adds.

Members in the program have chronic diseases that range from asthma and sickle cell disease to depression. A sizable percentage of members in the program are pregnant teenagers. "Unlike members in a commercial plan, the individuals in our programs have a complex array of psycho-social needs, along with multiple chronic conditions

with multiple comorbidities," Paquin adds.

Population is a tricky one

Medicaid members provide a challenge for case managers because the population is transient, often changing addresses, and they may not have telephones, says **Mia Lowe**, RN, CCM, CCP, director of case management.

"We utilize a lot of different forms to reach members, including calling providers and contacting pharmacies to get current addresses and phone numbers, as well as reaching out to members with postcards asking them to get in touch," she adds.

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Editorial Questions

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Many of the members have social issues along with their medical needs, she adds.

Attending to social needs first

"They may have trouble affording food and clothing or may be about to be evicted because they can't pay their rent. We have to take care of these needs first, before we can start helping them manage their health," Lowe says.

A team of social workers, one of whom is bilingual, team with case managers to help manage the needs of the members.

"We help them first with their social needs. If they are worrying about finding food or staying in their home, they're not going to take care of their health care problems," Lowe adds.

The social workers are familiar with community resources throughout Ohio and can help members get connected to programs and agencies in their communities that can meet their needs. If needed, the case manager can bring in a social worker or a behavioral health case manager to help meet the member's needs. If the member has trouble with medication compliance, the case manager can refer him or her to the pharmacy department for help.

About 6% of the members in the Covered Families and Children Program need case management, says **Candice M. Freil**, RN, EMBA, MHA, senior vice president of care management.

When new members enroll in the program, a CareSource nurse calls the parent or guardian and administers a health questionnaire to identify the presence of health conditions that require ongoing care. If the child has any of the conditions, the case is referred to a case manager who calls the parent or guardian and conducts an assessment to determine if the child is appropriate for case management.

Other members are identified through claims data analysis, referrals from local physicians and emergency departments, medical management staff, the health plan's 24-hours nurse advice line, and the on-site nurse liaison who is located at one of the hospitals with the largest volume of patients served by CareSource.

When a child is enrolled in the case management program, a nurse case manager calls the parent or child if he or she is old enough, providing education about the condition. The case manager works with the parent or child to set health care goals and to develop an individualized care plan and shares the plan with the

patient's primary care physician for input and follow up.

"In addition to the initial assessment when they enroll, if the members need case management, we conduct a more thorough disease-specific assessment and get the provider involved in developing a care plan," Freil says.

The case manager assesses the members' educational needs and makes sure they have information about their condition. They refer pregnant teenagers to agencies within their community that can provide them with help throughout the pregnancy.

Once the assessment is completed, the case manager stratifies the members according to their needs. The case managers get back in touch with the members according to their stratification and other needs.

The program is telephonic but case managers have the option to call on a home health agency for a face-to-face visit if it is necessary.

"The medical home concept is one of the biggest drivers for us," Freil, says.

Breaking the habit

Members in the Medicaid population tend to use the emergency department for primary care, a habit that CareSource wants to break.

"Once members come into our plan, we encourage them to pick a primary care physician and go for a visit as soon as possible. Our focus is to help these members find a medical home and get preventive health care. We want to educate them, that they don't have to sit in the emergency room for six or seven hours for a non-emergent condition," she says.

The case managers promote well child visits and talk to parents about getting regular check-ups and tests such as mammograms.

"We have a holistic care management program. Instead of separating case management, behavioral health, and social services, we offer family-oriented care management by a team that works closely together to coordinate care," she says.

The health plan contacts the members within 90 days of their enrollment to assess for case management needs. Based on their needs, some members are placed in case management for a short period of time. The majority of members receive case management for a year or longer.

"Some of the members have ongoing medical, behavioral health, and social needs and require interventions over the long run," Lowe says.

The health plan regularly reviews claims data to identify members, Freil says. "If claims data indicate that a member who no longer is in case management may need assistance, we contact them again and get them back into the program," she adds. For instance, if a member makes a visit to the emergency department or is hospitalized, the case manager gets back in touch with the member.

"We want to identify those members who are likely to have the highest utilization and provide appropriate case management," she says.

The health plan launched a new, similar product line in January for aged, blind, and disabled members who have comorbid conditions and complex needs. "Many of these members are aged. The majority have three or four comorbid conditions and take five to seven medications a day. About 60% have complex behavioral conditions as well as medical conditions and social and economic needs," says **Kimberly Byrwa**, RN, BA, CPHQ, director of case and disease management.

The case managers help the members locate resources within the community that can help with their housing, transportation, and other needs, Byrwa says.

"The case managers help the members identify opportunities to improve their health. They help them understand their pharmacy benefits and become compliant with medication. At the same time, they communicate with the treating physicians, forwarding the information we have gathered and the care plan we have developed for the member in terms of education and resources," she says. ■

Plan complements disease management program

Targets ill at risk for health care expenditures

Members with chronic conditions that put them at risk for high health care costs but don't fall into traditional disease management programs are learning how to manage their conditions through the ComplexCare program from Health Management Corp.

"We've recognized for a long time that dealing

with the core disease management conditions can have a positive outcome for people who are at risk, but there also are people with multiple chronic conditions who do not fall into traditional disease management categories but who account for a lot of expense and poor outcomes," says **Sam Cramer**, MD, chief medical officer for Health Management Corp.

Health Management Corp., a wholly owned subsidiary of WellPoint, with headquarters in Richmond, VA, supplies disease management and case management for WellPoint and other clients.

ComplexCare helps members avoid preventable episodes of care by seeing a physician regularly and following their care plan, complying with their medication regimen, setting lifestyle goals, and following healthful practices, such as dieting and exercising.

The program provides outreach to at-risk members who may have conditions such as cancer, multiple sclerosis, muscular skeleton problems such as fibromyalgia and behavioral health conditions such as schizophrenia and bi-polar disorder. Members with the core disease management conditions — asthma, diabetes, chronic obstructive pulmonary disease, heart failure, and coronary artery disease — are referred to the health plan's traditional disease management program.

Predictive model used to identify members

The health plan identifies members through a predictive model that is based on utilization and laboratory claims and targets those who appear to be at risk for future utilization. For example, the model identifies members who regularly see three or more doctors, have three or more emergency room visits within six months, or have more than two hospital admissions in a three-month period. Additional members who might benefit from the program come from the results of a health risk assessment, referrals from physicians, and the health plan's utilization management department.

When members are identified, a health outreach specialist calls them on the telephone, explains the program to them, and enrolls them if they are willing to participate. The outreach specialists collect initial demographic information, and then transfer members to an RN care manager. The care manager verifies the member's medical history and diagnosis, then conducts an assessment of the member's functional status, social and economic status, support system, and any needs they may have beyond their medical condition.

"So many things besides a patient's medical condition have an effect on their health. We do a very complete assessment in terms of medication, transportation issues, the type of support they have at home and use the information to develop a care plan that looks at all of their needs and what we can do to help," Cramer says.

The care managers provide information that helps the enrollees understand their conditions and their medication instructions. They work with the members to develop a care plan that includes lifestyle goals and health-related priorities.

"The goals are based on the most important steps that the member should take to stay healthy, and at the same time, the care manager takes into account what goals the individual is most ready or most willing to work on. They have to balance the two," Cramer says.

For instance, if the member needs to stop smoking or lose weight but isn't ready to address that issue, the care manager and member may decide to start to work on medication compliance and tackle smoking or weight loss later.

"It's not just the nurse and clinicians who drive the care plan. We want the individuals to buy into it," Cramer says.

The care manager may contact the member's primary treating physician to determine or clarify a plan of care for the member. The care manager notifies the physician that the member has enrolled in the program, and shares the member's care plan and the goals, and provides status updates. The care managers work with the members to help them follow their physicians' plans of care.

"One of the roles of the nurse care manager is to make sure the members have providers and see them on a regular basis. Some have lost contact or don't have a primary care provider. The care managers facilitate getting the members in to see their physician," Cramer says.

The plan has medical director oversight at every call center who reviews the new enrollees and is available for consultation if the care manager needs information or if the treating physicians have a question.

Members are stratified by acuity level, which drives the frequency of the telephone calls from

the care managers. The nurse care managers call participants at least once every six weeks. Members also can contact the nurses with any health-related questions using a toll-free number.

The program is designed to provide support for six months to a year to help members meet their health care goals. If a member is still not meeting his or her goals after a year, the nurse care manager consults the medical director to determine if the member is still appropriate for the ComplexCare program or if he or she might benefit more from a different type of program.

The care managers help members obtain referrals for specialty care, home health services, durable medical equipment, and other needs. They also work with members to help them obtain community services such as free transportation for health care visits, Meals on Wheels, or other services.

"We are not CPAs or lawyers, but our members may need these services. Beyond dealing with the clinical issues, we help the members find the resources they need to solve their problems," Cramer says.

Care managers located at call centers around the country coordinate the care of members nationwide. The care managers have resource guides for individual areas and rely on other colleagues at other locations for help in identifying the community organizations that can help the members.

"The nurse care manager is the expert in terms of resources. They don't know every resource in every location but they know how to find them," Cramer adds.

The care managers also conduct assessment screenings to identify members who might benefit from a mental health program. "People with chronic conditions frequently become depressed and depression can have an impact on their medical condition. They may not be as compliant as they should be because of mental health issues," he says.

If the care manager identifies that the member has severe behavioral health or mental health issues, she connects him or her with a mental health program and follows up to make sure that the member has kept his or her appointments.

The care managers assigned to the member work with the pharmacy staff on medication compliance. They can consult with exercise physiologists, dieticians, and other ancillary providers if needed. ■

Program helps members manage their weight

A newly diagnosed diabetic, we'll call him Mr. Smith, called in to Capital District Physicians' Health Plan Health Coach Connection because his doctor had told him he needed to undergo gastric bypass surgery if he was going to live another 10 years.

Smith was concerned and wanted to explore other options.

The health coach sent the member a decision-support video along with information on diabetes, nutrition, and healthy lifestyles. The health coach also referred the member to the health plan's Weigh 2 Be weight loss program, which provides adults with multiple resources for weight loss and healthy lifestyle choices, including interactive web-based tools to design customized weight loss plans and fitness programs, and offers community classes, and other support.

Smith decided not to have the surgery but, with the help of the multidisciplinary team at the health plan, worked on losing weight and exercising.

Health Coach Connection staff spoke to the member 11 times in eight months, offering him help with losing weight and getting his diabetes under control.

He lost 65 pounds in seven and a half months, got his blood sugar under control to the extent that he could stop taking medication for diabetes, and is scheduled for sessions with a respiratory therapist who will help him quit smoking.

"This illustrates how the various departments within our health plan collaborate, trying to keep people healthy and out of the hospital," says **Mary Ann Roberts**, RN, health educator for the Albany, NY-based health plan.

Nurses, dieticians, respiratory therapists, case managers, and disease managers at Capital District Physicians' Health Plan and Health Coach Connection work together to ensure that members have all the tools and support they need to maintain a healthy lifestyle.

The health plan offers Weigh 2 Be for adults and KidPower for children, both programs that help participants learn to manage their weight and improve their health. The health plan started its adult weight management program

in April 2003 to respond to the increased prevalence of obesity and comorbidities, such as hypertension and diabetes, that are linked to diabetes, Roberts says.

The program is designed to help participants learn to manage their weight and improve their health, and the statistics have been encouraging, Roberts points out.

In 2006, 79% of adults responding to the health plan's Weigh 2 Be program reported reductions in their body mass index.

The health plan developed and implemented a KidPower weight management program for children ages 5 to 17 to address the growing childhood obesity epidemic. "Research indicates that there has been a dramatic increase in Type 2 diabetes and hypertension in children. The objective is to keep people healthier and prevent disease, while simultaneously improving their quality of life and lowering the cost of health care," Roberts says.

Capital District Physicians' Health Plan sent out an introductory mailing describing the Weigh 2 Be program to more than 30,000 members with diabetes and/or hypertension.

In addition, adults are referred to the Weight 2 Be program by their physicians, nurse case managers or by self-referral.

When members enroll in the program, they receive a packet of information on nutrition, stress management, fitness, a discount on the purchase of a pedometer, and a rebate offer of $64 off the completion of a 10-week Weight Watcher's program.

"We partnered with Weight Watchers since this was the most sound and evidence based weight loss resource. It helps participants learn portion control and how to eat healthfully," Roberts says.

Members who sign up for the program can access interactive fitness and weight loss tools on the health plan's web site. They can enter their weight and other measurements on the site to determine their body mass index, and calculate the number of calories they are consuming each day by entering information on what they eat and drink.

In response to surveys from members who wanted more personal contact, in May, the health plan developed a Weigh 2 Be pilot program of six, one-hour classes in the community. Experts speak to participants on topics ranging from hypertension and stress management to cooking and exercise demonstrations.

Members weighed in each week and received a small incentive each week, such as a stress ball, fitness bands, or portion control dishes. About 60% of enrollees participated in all six classes.

"We want to give them the resources they can use at home to be successful in their weight loss efforts," Roberts says.

Because the class attracted participants from their 30s to their 80s, the speakers covered subjects that would be of interest to everyone. For instance, the fitness instructor taught exercises that people could do in wheelchairs, sitting down, or standing up.

The health plan offered a second round of Weigh 2 Be six-week programs again in September. More than 125 members enrolled in the second round, many of whom participated in the first pilot program.

In October, the plan started sending out a quarterly newsletter to Weigh 2 Be participants.

"Each quarter will address different options for making healthier lifestyle choices," Roberts says.

Each child enrolled in KidPower receives a backpack filled with items to promote healthy eating and fitness, including a book explaining nutrition, fitness, and behavior modification techniques. Color-coded stickers and a refrigerator magnet included in the packet help kids identify foods they should consume in small, medium, and large quantities. A fast-food slide guide and an offer to purchase a pedometer are also included.

The health plan was the first to partner with Radio Disney to present its Move It! programs throughout the community. The program, which aims to get children involved in physical activities, sends the Radio Disney van to community locations and presents a fitness program that may include hula hoops, dance, or creative movement. Kids receive collectible Disney pins for participating.

The health plan has launched a six-week KidPower pilot program of classes for children ages 10 to 15. Participants attend the classes for an hour each week, working with either a children's fitness expert or a children's nutritionist. The class includes fitness stations where the kids try their hand at activities such as hula hoops and beach balls.

"Many of these children can't run and compete in the same activities that other kids their age can. We designed the program so everybody could be successful," Robert says.

Participants in the program bring in a sheet each week showing that they have done 15 minutes of fitness activities each week. At the end of the program, the sheets will be entered into a drawing for an iPod Shuffle. ■

It is National Pancreatic Cancer Awareness Month

Teach public best prevention techniques

Pancreatic cancer makes headlines when someone famous dies of the disease such as Luciano Pavarotti, the world-renowned opera singer that lost his fight with the disease in early September 2007.

Otherwise, the general public does not pay much attention to the disease.

"Most people probably don't even know they have a pancreas and what their pancreas does," says **Michelle Duff**, DPT, director of patient and liaison services and medical affairs for the Pancreatic Cancer Action Network (PanCAN) located in El Segundo, CA.

To bring more attention to the disease and increase research funding, PanCAN has designated November as "National Pancreatic Cancer Awareness Month." According to PanCAN there is a great need for early detection and better treatment options for the deadliest of all cancers. Currently, 75% of all patients with pancreatic cancer die within 12 months of diagnosis. It is ranked as the fourth-leading cause of cancer death in the United States.

"We have so few answers and we understand so little about the disease compared to other types of cancer," says Duff.

While knowledge of pancreatic cancer prevention and detection is probably where breast cancer was 50 years ago, there is a lot of information the general public needs to know, adds Duff.

First, people need to know if they have immediate family diagnosed with pancreatic cancer, they should talk to their physician about their risk and the possibility of participating in a screening protocol.

"Those who have a family history of the disease can participate in some type of surveillance or screening protocol to see if the doctors can see types of changes to help determine if something abnormal is happening," explains Duff.

Also people need to understand there are treatment options and physicians who specialize in the disease, so if diagnosed they can choose treatment. While much research is needed, some patients do very well with treatment, according to Duff.

"We don't want people to think that because this is an uphill battle they shouldn't even try. We have a whole network of people who are surviving and talk with others that are diagnosed with this disease so they know there is hope," says Duff.

PanCAN works to not only raise awareness and increase funding for pancreatic cancer but also to support those diagnosed with the disease.

Best ways to prevent pancreatic cancer

The American Cancer Society predicts that in 2007 about 37,170 people in the United States will be diagnosed with pancreatic cancer and 33,370 of these patients will die of the disease.

Because pancreatic cancer is such a deadly disease, the best scenario is to prevent it in the first place. Yet there is not a lot known about how the disease develops. One risk factor for pancreatic cancer is smoking. According to the American Cancer Society, people who smoke are two to three times more likely to develop pancreatic cancer. Three out of 10 cases of this cancer are thought to be caused by smoking.

Other factors include a family history, obesity, and lack of physical activity. The risk of developing the disease goes up with age as well. The average age of diagnosis is 72, with 90% of the cases diagnosed in peopled older than 55.

There also seems to be some connection between diabetes and pancreatic cancer but it is not known if the diabetes is being caused by the pancreatic cancer or vice versa, explains Duff.

While there is no solid information on particular foods to eat to prevent pancreatic cancer, it is recommended that people eat a well-rounded diet with plenty of fruits and vegetables. The American Cancer Society recommends people cut back on red meat, especially meat that is processed or high in fat.

The typical symptoms that prompt people to seek a medical diagnosis are jaundice, unexplained weight loss, pain, and indigestion. Because warning signs are vague, the pancreatic cancer is usually more advanced by the time it is diagnosed.

"We don't have good early warning signs and we definitely don't have good early detection tools for this disease. Occasionally, someone has a tumor in just the right location so it will cause jaundice when it is small and then people will go to the doctor when it is in an early stage," says Duff. ■

Project targets diabetes in Latino community

'Secondary gains' affect willingness to accept help

The "yes-means-no" phenomenon was one of several challenges encountered by the team conducting a community case management pilot project for diabetes patients in Nogales, AZ, says **Donna Zazworsky**, RN, MS, CCM, FAAN, diabetes care center manager for the Tucson-based Carondelet Health Network.

The project — which targeted emergency department (ED) "frequent fliers" with diabetes — focused on establishing the care team and developing a case management toolkit for home diabetes education visits, she adds.

"Nogales is primarily a Latino community, with a very high incidence of diabetes," Zazworsky notes. "Carondelet Holy Cross Hospital had started an inpatient case management program where anyone hospitalized with diabetes would be seen by a nurse case manager/diabetes educator and referred to diabetes self-management classes held in the community."

This helped people who were hospitalized, but the process missed those ED frequent fliers with diabetes, Zazworsky says. "These individuals were not making their way to the classes.

"Many of these patients said that it was just too hard to get to the classes," she explains, "or there was a secondary gain they had. In one case, a gentleman wanted to get on disability and needed to get documentation, so he didn't want to get any better.

"Others wanted to [use their disease to] get attention from family," Zazworsky says. "They had the wherewithal to get to classes, but just didn't go."

Another barrier identified by the team was "the concept of 'yes means no,'" she points out. The phrase, used as the title of a book written in regard to Native Americans, also applies to Latinos, Zazworsky says. "It's not polite to tell you, 'No, I don't want to do that,' so they say, 'Yes.'"

Carondelet Holy Cross Hospital in Nogales received a grant from the Arizona Department of Health Services to conduct the pilot project in March 2007, she says, and had to complete it by June 30. We had to use [the funds] by the end of the fiscal year.

As part of the pilot project, the team used assessment tools from the Case Management Adherence Guidelines (www.CMSA.org), as well as a risk assessment tool already in place for Carondelet diabetes inpatients, Zazworsky adds.

The tools were translated into Spanish by a licensed translator from the area who works with the Carondelet system, Zazworsky says.

"The bottom line was that we were able to get patients into the program and agree to have a nurse case manager make a home visit," she says. "The key was the ED nurse, who provided patient referrals to the community nurse case manager and explained the program to patients. There had to be some kind of handoff so that the patient was aware of the program."

To facilitate that process, Zazworsky notes, the ED nurse made 3x5 note cards explaining that the nurse case manager would call to set up a time for a home visit in order to see how she could help the patient.

The nurse case manager would call within 24 hours to set up the visit, and would then make the visit within 48 hours, Zazworsky says. During the visit, she adds, the nurse case manager would use the tools to gauge the patient's knowledge, readiness, motivation, and literacy level in regard to the diabetes.

The project evaluation process showed that even with short-term nurse case management interventions in the home, the target goal of 4.5 out of 5 in confidence levels was met in these areas:

- make healthy food choices (4.5);
- identify foods with carbohydrates (4.5);
- find diabetes information and support (4.5);
- detect and take action for low blood sugar (4.8);
- examine feet for problems and know how to care for them (4.6);
- work with a health care provider (5).

(Editor's note: ***Donna Zazworsky*** *can be reached at donnazaz@aol.com.)* ■

CM salaries are increasing, but so are the hours

More paperwork and assignments present challenges

Salaries for case management are increasing, but the vast majority of case managers are working far more than the traditional 40-hour week, according to the results of the 2007 *Case Management Advisor* Salary Survey.

The 2007 Salary Survey was mailed to readers of *Case Management Advisor* in the June 2007 issue. Almost half of the respondents (42%) were in case management supervisory jobs and 25% were case managers. The rest were company presidents, vice presidents, owners or held other positions.

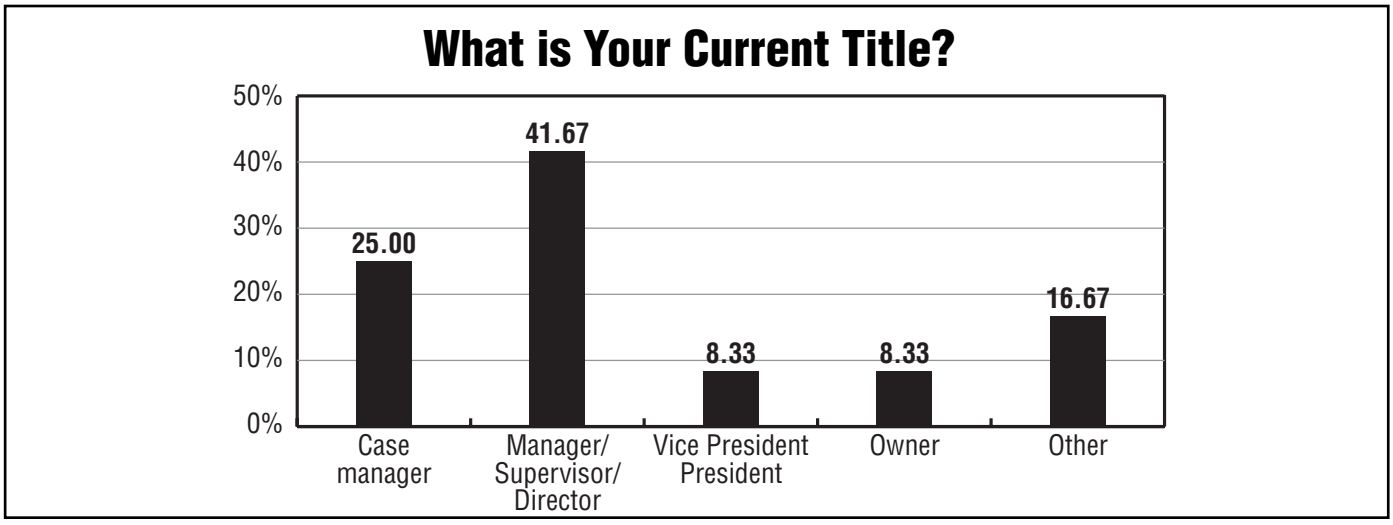
Respondents to the survey report putting in long hours. The vast majority of respondents (91%) report working more than 40 hours a week, with more than 16% reporting working 51 hours or more.

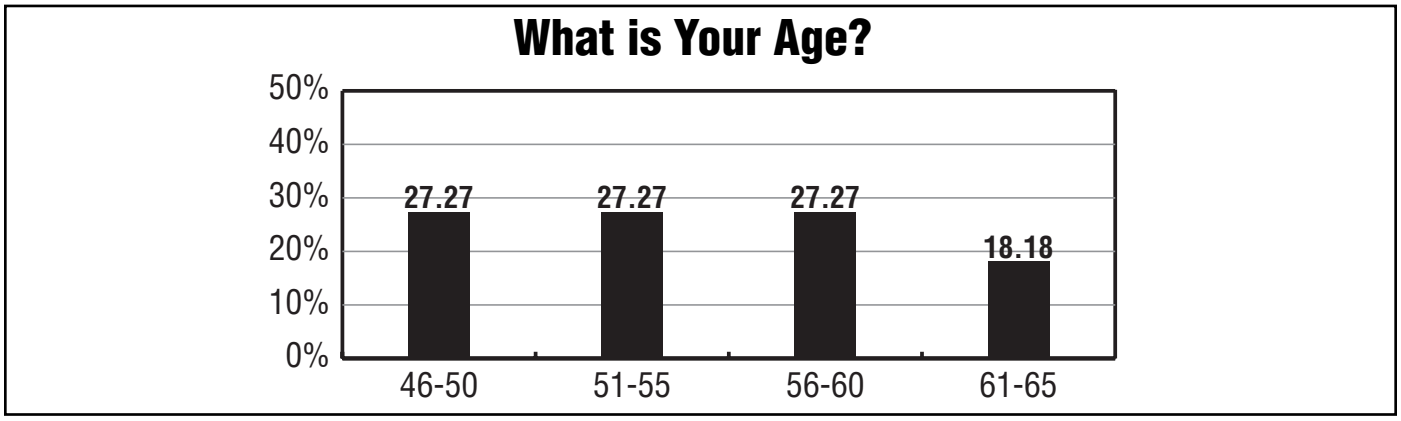
Today's case managers are spending a lot of time doing assessments rather than addressing some of the problems of the people they are assessing, says **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president of Mullahy and Associates.

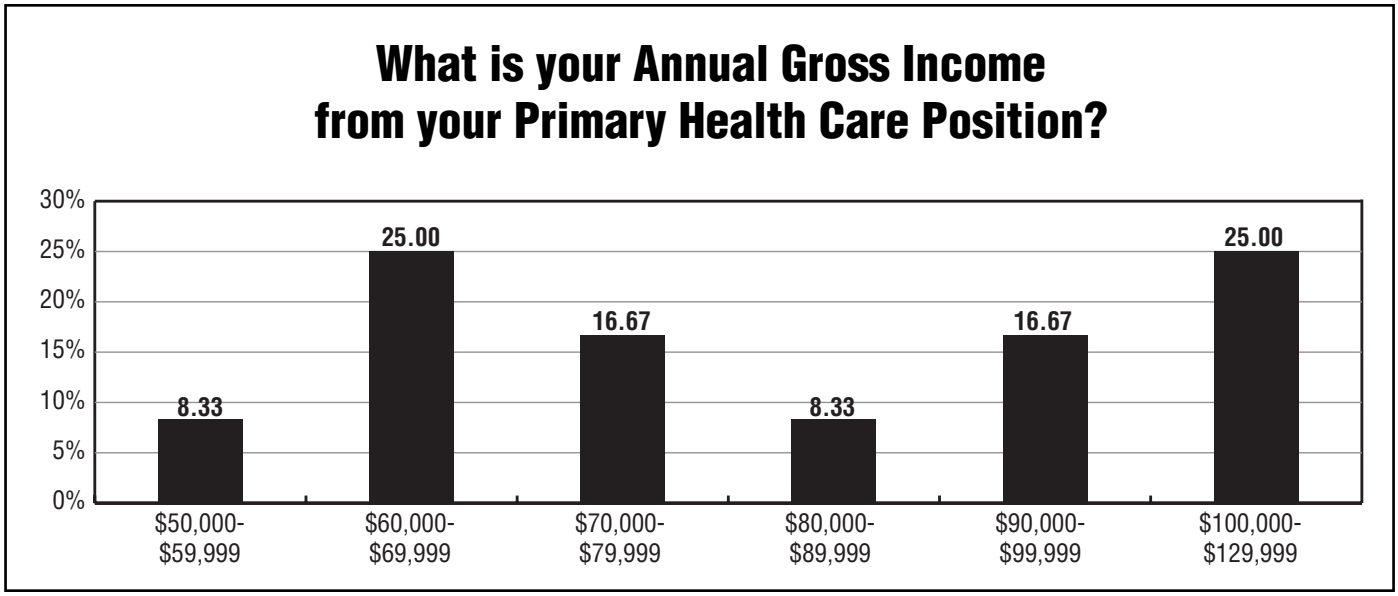
"Nurses across the board, especially in disease management and case management, feel that they spend more time documenting and filling out forms, rather than doing the things they feel will make a difference, leading to an increase in job dissatisfaction," she says.

At one time, nurses were attracted to case management because it was a Monday through Friday job with no holiday or weekend work. Now a lot of organizations have expanded the hours they want covered. For instance, there are nurse triage lines that operate 24 hours a day and disease management nurses who call on people in the evenings, Mullahy says.

As payers are requiring evening and weekend discharges, hospital case management departments try to keep weekend work to a minimum by recruiting specific nurses for weekend and evening shifts, adds **Steven L. Robinson**, director of KPMG LLP's health care advisory services. For instance, New York Hospital Queens has a social worker on staff who works only weekends. The







staff of 23 case managers rotate weekend duty, according to **Caroline Keane**, director of case manager and social work. Case managers and social workers who work until 8 p.m. on weekdays receive an evening differential.

Case managers tend to be among the most experienced of nurses, with 92% of respondents working in health care for more 25 years or more. More than 91% of case managers responding to the survey reported getting a raise last year. The highest percentage of respondents (67%) reported getting a 1% to 3% raise, followed by 25% whose salary increases were between 4% and 6%.

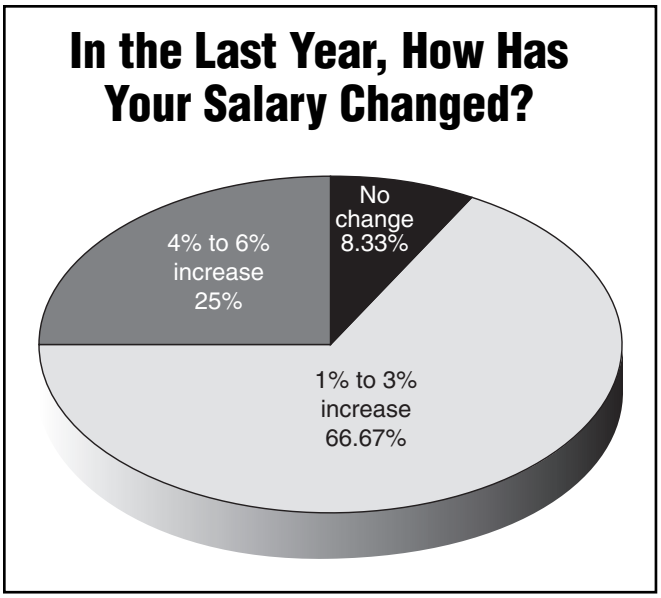
Well more than half (65%) of respondents to the survey report salaries of $70,000 or more with 25% reporting salaries of more than $100,000.

Salaries for case managers tend to vary widely, depending on the practice setting, points out **B.K. Kizziar**, RN-BC, CCM, CLP, owner of B.K. & Associates, a Southlake, TX, case management consulting firm.

"Hospital case managers seem to be the lowest on the pay scale, with case managers who practice in managed care settings near the top. Commercial payers have always led the way for case managers. They have appreciated the value that case managers can bring to the table," she says.

Compensation for independent cases managers often varies depending on the job and the setting. "Salaries for independent case managers can run the gamut because they are as busy as they want to be," she adds.

On the other hand, there tends to be a wide range of differences in pay between nurses and social workers in any organization, Kizziar says. Many social workers have master's degrees but



they are paid less than nurses who may not have a post-graduate degree, she adds.

The size of case management departments appears to have remained fairly constant over the past year. A third of respondents reported that their department had increases, with only 8% reporting a decrease in staff and 58% reporting no change.

However, the nursing shortage has impacted almost every aspect of nurse staffing, and case management is no exception, Robinson says. "From our observation, case managers are highly skilled professionals with a clinical nursing and management background. Those skills are difficult to attract," he adds.

Hiring qualified case managers continues to be a problem that is attributable to the nursing shortage but goes even further, Mullahy points out. "Even if we did have young men and women interested in going into nursing, the academic settings are having difficulty filling faculty positions. We don't have qualified people to teach. And, too, academic settings don't pay as well and nurses still have to feed their families and pay their mortgages," she says.

As a result, some nurses who become case managers don't have sufficient experience or training and may be unprepared for the job.

In large organizations, the person who hires the case managers may be a vice president of human resources and feel "a nurse is a nurse is a nurse and may not realize the additional experience and skills that are needed," Mullahy says.

"They have a couple of days' orientation and then they have a caseload. New case managers need to partner with more experienced ones so they don't get overwhelmed," she says.

Along with the gloom, there are opportunities for case managers, says **Harry Leider**, MD, MBA, chief medical officer for XLHealth.

"The growing burden of chronic illness in the Medicare population and our nation's need to address cost and quality presents wonderful opportunities for case managers. There are many exciting roles for case managers in health plans and disease management organizations including: telephonic health coaching, face-to-face patient evaluations and education, coordination of complex cases, and more traditional utilization management roles," Leider says.

For instance, Care Improvement Plus, a subsidiary of XLHealth, provides care coordination for seniors with chronic illnesses through its "Special Needs" Medicare Advantage plan. Every member in the program receives telephonic disease management from a health coach who is a registered nurse and face-to-face meetings with a nurse case manager. The program has grown from a pilot with 300 members in 2006 to providing care for more than 60,000 Medicare enrollees in six states. ■

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. ■

COMING IN FUTURE MONTHS

- Improving maternal and child health outcomes
- How to help cancer patients choose the right treatment options
- Ways to help members prevent osteoporosis
- How disease management lowers hospital readmissions

CE questions

17. According to **Mia Lowe**, RN, CCM, CCP, why are Medicaid members a challenging population?
    A. They are transient.
    B. They may not have telephones.
    C. A & C
    D. None of the above

18. The ComplexCare program from Health Management Corp. does not consider utilization as a factor in identifying members.
    A. True
    B. False

19. In 2006, what percentage of adults responding to the Weigh 2 Be program reported reductions in body mass index?
    A. 49%
    B. 54%
    C. 64%
    D. 79%

20. Currently, there is not a great deal of information on what prevents pancreatic cancer, but there seems to be a connection between smoking and the cause of the disease.
    A. True
    B. False

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

CE objectives

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

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

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