

Case Management

ADVISORTM

Covering Case Management Across The Entire Care Continuum



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Patient-centric care coordination decreases hospitalizations, ED visits

Program combines face-to-face, telephonic case management

A combination of face-to-face and telephonic case management has resulted in high patient satisfaction ratings and a significant decrease in health care utilization for patients with complex medical needs.

The care management program, provided by Alere, an Atlanta-based health management firm, resulted in a 38% decrease in hospital admissions, a 36% reduction in hospital days, and a 30% decrease in emergency department visits for patients who are members of one health plan, according to a 2007 study.

Alere's care management team provides care coordination for patients with life-limiting diagnoses or significant chronic disease.

About 60% to 70% of patients in the program have advanced cancer. Others have multiple comorbidities, such as heart failure, diabetes, chronic obstructive pulmonary disease, coronary artery disease, and hypertension.

Care managers live in the same community as the majority of the patients they support and carry a caseload of about 22 patients at a time.

"We limit the caseload because of the intensity of resources patients in the complex care management program need and the amount of attention they require," says **Albert Holt**, MD, MBA, senior vice president and senior medical director for case management and disease management programs for Alere.

The care managers conduct an initial assessment in the patient's home or hospital room and follow up by telephone. If there is a change in the patient's status or the patient is going to another level of care, the care manager makes another home visit.

If there isn't an Alere care manager nearby, the company sends a nurse case manager to that area to complete the in-home assessment.

The key to the success of the care program is taking a personal

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approach to care coordination and building a relationship based on face-to-face contact and working with the patients on goals that they identify as important, Holt says

“When the care managers go into the patient’s home, they get patients’ perspective on illness and what they want to achieve. They collaborate with the patients and family members to set goals based on what patients want to do and develop a plan to help them meet their goals. Because patients are engaged in their own health care, they are able to keep their conditions from getting out of control and avoid hospitalization or visits to the emergency department,” he adds.

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Alere identifies patients eligible for the program by screening claims, precertification, medical information, and other data from their insurance plan and employer group clients.

“We concentrate on precertification and immediate hospital data because we want to get patients when their illness is new to maximize our assistance to them,” Holt says.

The organization’s triage enrollment nurse calls eligible patients and completes an assessment to determine the client’s clinical status and need for case management and enrolls interested patients in the program.

The care manager who is assigned the case sets up an appointment for a comprehensive in-home assessment that typically lasts several hours, says **Linda Alden**, RN, CCM, a complex care manager based in Southern California.

“We always encourage family members to be present when we meet with the patients. We’re collecting and offering a lot of information, and it’s always good to have more than one set of ears listening,” Alden says.

The care managers already are familiar with the patients’ medical history but they also find out the patients’ perception of their disease process.

‘Perception is reality’

“Perception is reality. We often have cancer patients who are recovering from surgery and don’t expect to have to have chemotherapy or radiation because the surgeon told them they removed the tumor and the margins were clear. If we know what they perceive, we can start the educational process there,” Alden says.

During the initial visit, the case manager completes an in-depth assessment of the patient’s symptoms, resources, and support system, says **Nancy Messenger**, RN, CCM, a care manager based in Northern Michigan who coordinates care with indemnity patients, often traveling throughout the country to meet them in person.

“We want to get a full and total picture of the patients and their needs during the face-to-face visit. One of the joys about this job is the flexibility we have to give our patients personal service and do whatever is needed to meet their specific needs, whether it’s financial assistance, education, transportation, or help with meals or housekeeping,” Messenger says.

After the initial assessment, the care managers develop a dynamic care plan and discuss it with their nurse supervisor, called a clinical support

manager, and their medical director.

All of the complex case management cases are reviewed twice a month by the medical director to provide additional support and keep the clinical guidance on track, Holt says.

"The medical directors keep on top of chronic diseases and oncology regimens and can call on specialty experts when needed. For instance, if a patient has a complicated diabetes regimen, they can call on a diabetes specialist for advice," he says.

At the time they open a case, the care managers send a letter to each of the patient's physicians introducing the case management program to them.

The care managers identify one physician who is the primary physician and collaborate with him or her. For instance, if the patient is undergoing cancer treatment, the oncologist is likely to be the primary physician.

"Our relationship with the treating physician is very important," Alden says. "Patients are on the phone with us for an hour at a time and talk to the doctor's office for five minutes. They tell us things that they don't share with the providers. We give them additional information to help them make clinical decisions."

Facilitate communication among physicians

Most of the patients in the program are being treated by multiple providers, most of whom do not regularly communicate with each other, Messenger adds.

"We facilitate communication among the treating physicians to make sure the patient's care is coordinated," she adds.

The nurses take a patient-centric approach to coordinating care, Holt says.

The complex care team treats the whole patient, not just the issues they are called in to address, Alden adds.

"We may be working with a cancer patient, but when we conduct the assessment, we find out he or she has hypertension. We incorporate education on managing hypertension, such as diet, exercises, and medication compliance, into our care plan for cancer," she says.

The care managers call their patients at least once a week and encourage them to call any time they need help.

"Because we're not a family member, a friend, or a physician directing their care, patients often feel more comfortable speaking with us. We can

find out what's going on with them and alert their health care providers if needed," Messenger says.

That first face-to-face visit helps the care managers get to know the patients and their families and start to build a relationship.

"We become more than just a voice on the phone. We are alerted to safety issues when we visit the home, but we also find out what brings the patients joy. We can see their hobbies, pets, and family members and use that information to personalize our conversations instead of talking only about their disease or treatment," Alden says.

When patients have cancer, the care managers educate them on the possible side effects of treatment and how to overcome them.

Patients with cancer are undergoing active treatment and need support in understanding their options, learning what to expect from treatment, and how to coordinate their health care needs. Some are so far advanced that they are transitioning into the terminal stage, Holt adds.

"Almost every cancer patient tries to be as positive as possible, but they all have a day when everything seems to fall apart. Chemotherapy can be very debilitating. We try to keep them emotionally stable and encourage them to forge on ahead," Alden says.

Advance directives discussions key

The care managers bring up the subject of advance directives during the initial assessment and work with the patients and family members to ensure that they are in place.

"I always tell them that I recommend this to all my patients and that I have completed my own advance directives. I don't want them to think that I know something they don't know. I tell them that when they are ready, I can walk them through it," Alden says.

The care management organization has won awards for the care managers' successful discussions with patients about advance directives, Holt says.

"About 20% of our patients die during the course of complex case management, and more than 70% of them have advance directives documented," he adds.

When a patient's condition starts to deteriorate, the care manager starts discussing end-of-life issues and possible hospice care.

"Every case is unique, and everybody reacts to

end of life in different ways. Because we know these patients so well, we know how to address it," Alden says.

Educating patients on advance directives and end-of-life options is a service to the patients, Messenger says.

For instance, one of Messenger's patients had a terminal diagnosis but didn't know about it.

"It wasn't my place to tell him so I steered him back to his physician to have the conversation when I determined that he wanted to know," she says.

She spoke to the patient as he was leaving his physician's office, stunned by the news.

"I asked if he was alone and if he was OK to drive. The next time he saw me, he thanked me. By finding out about his diagnosis, he had time to make advance directives and put things in place for his family," she says.

Patients stay in the program as long as they need assistance. Patients undergoing cancer treatment usually stay in the program until they are well educated and have met their goals.

"We make sure they are very clear about their follow-up regimen and all the health care screenings they need to have," Messenger says. ■

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