CASE MANAGEMENT OF DISABILITY CLAIMANTS

Joan Herzog, RN

DR. BOREN: Our next speaker, I'm very proud to say, is one of my colleagues from CNA Insurance, Joan Herzog whose in charge of case management. Joan got her bachelor's in nursing from Loyola University here in Chicago. She got her master's from St. Francis of Joliet, a city a little southwest from us. Joan has been very active in all the organizations for case review and she's going to talk to us about the case management of disability.

MS. HERZOG: Thank you, Steve. Good afternoon. This is nearing the end of the day and from a speaker's perspective, it's not the best time to have to give a presentation. And because I'm speaking to a group of physicians, I'm a little nervous. So I thought the best way to begin is to start with some humor. So I'd like to tell a joke which is not typical for me when I make presentations, so please bear with me.

There were two medical researchers who were conducting a study on Alzheimer's and they were looking for subjects for the study. And they had some requirements in trying to identify the appropriate subjects for the study. Their requirement was, of course, that the individuals had Alzheimer's, but secondly, that they had early Alzheimer's in that they still had the ability to do simple mathematical problems.

So they identified three potential subjects and they asked each individual a question. They asked Mr. Smith, "Mr. Smith, what is three times three?" And Mr. Smith thought for a moment and he said, "Three times three, that's 166." And they said, "Oh, my gosh. This individual certainly doesn't meet our requirements."

Then they asked Mrs. Brown, "Mrs. Brown, what is three times three?" And Mrs. Brown said, "Three times three, I think that's red." Well, they thought, wow, this one is further out than the first person.

Then they asked Mr. Jones, "What is three times three?" And Mr. Jones said, "That's an easy one. Three times three is nine." And then one researcher said to the other one, "Well, gee whiz, maybe we better make sure that he's okay and that he actually knows the answer. So I think I'll ask him how he got to that question." So they asked him how he did it. And he said, "Well, I subtracted red from 166."

(Laughter.)

MS. HERZOG: Thank you. I think that joke is rather appropriate for my topic today which is case management, particularly when you talk about case management as it relates to the management of disability claims. I look at it as being 166 plus red minus yellow plus blue. In other words, it's a very complex topic.

Case management in and of itself has numerous variables, many of which are out of the control of the case manager. So what I'm telling you is that bringing case management and the concepts of case management to the disability arena, is a challenge to those of us who are in the case management field.

I've been involved in this field for ten years and throughout the ten years, it has grown enormously. Case manager ranks have swelled to the point where there is a credential for case managers. I am a certified case manager and when this credential was introduced two years ago, there were over 10,000 applicants. Case management has also spawned a cottage industry of dissatisfied healthcare professionals who were really frustrated trying to work with public and not for profit delivery systems.

So they became entrepreneurs. Case management has also fostered huge marketing efforts by alternative care providers. I think case management has been one of the primary initiators for the growth in home care and the growth in durable medical equipment, for the growth in high tech home care delivery companies and so on and so forth. It has also brought forth large conferences in educational efforts.

The two major associations several years ago had perhaps 300 attendees, similar to this organization. Now they have upward of 3,000 people attending and I think the last conference I attended there were over 300 exhibitors. So as you can tell from that, this is a very large and growing field.

Today I'm really going to present case management from a company's and employer's perspective. I know that there are many of you here who are working in individual lines of business but the line of business that I'm most familiar with and that I have worked with is with employer groups. So I will be speaking from that perspective.

Over the next 30 minutes I'm going to begin my presentation by giving you some definitions of case management. I think that's a good place to start. Then just a brief overview of the different
models of case management, then the opportunities and challenges that disability management presents to case managers.

I've been also asked to provide you with some case examples, and that was not an easy task because disability management, the use of case management in disability management is very new. We've barely scratched the surface, so we don't have a lot of experience to draw from.

And then finally, what I'd like to wrap up with is talking about your role, the medical director's role in case management, and that will primarily be coming from my point of view because at this time I have not seen a lot of involvement of the medical directors in the insurance company. I think that there are opportunities for all of you within that realm.

As I went through thinking about a definition appropriate for this presentation for case management, I came up with two. There are many, depending upon the audience, depending upon the type of program, depending upon the goals. But I think the two definitions that I'm presenting to you today fit very well with the topic at hand.

The first definition is that from the National Coalition of Associations for the Advancement of Case Management, and they define case management as a collaborative process that promotes quality care and cost effective outcomes which enhance the physical, psycho-social and vocational health of individuals. It including assessing, planning, implementing, coordinating and evaluating health related services.

I think this definition is very appropriate, number one, because it stresses that case management is a collaborative process. When you get into the realm of disability management, it has be a collaborative process from the individual with the disability to the insurance carrier involved to the employer to the attending physicians, consultants and all of the various players involved in the process. Unless all of these disciplines work together, case management won't be successful.

I think the other part of that definition that's appropriate to the management of disability claims is that it encompasses the physical, psycho-social and vocational health of individuals. As I go through the models you will see that the models that exist today only address segments of that definition.

And lastly, that case management evaluates health related service options, I would add there that it also evaluates job related service options. That is particularly important when you're looking at managing disability.

The second definition that I like — and I think this is probably my favorite — and this is a definition that Karen Kaplan who was the director of the National Center for Social Policy and Practice identified. She defines case management as the delivery of the right services at the right time. Done correctly, case management works because it helps insure top quality care delivered in a timely fashion. It allows the use of appropriate specialized services that maximize recovery. I think the key words there are right services at the right time.

Being involved in case management for the number of years that I have, I have seen numerous successes because we were there at the right time providing or coordinating the right services. I have seen many failures for the opposite reason. We got in too late and therefore it was difficult to coordinate the right services because the services were already in place. Timeliness is key and that presents a challenge to all of us because then the realm of disability, typically in the past, we've gotten involved at a very late point in time.

So that is a challenge for us to get in much earlier. And it allows the use of appropriate specialized services. I think appropriate is another key word because there can be a plan in place and it can be cost effective, but it may not be appropriate for that particular individual's needs or circumstances.

There are a number of case management models, but I think four that particularly come into play and each of these four provide different management for different pieces of disability.

The first is the rehabilitation model. The rehabilitation model is focused on worker's compensation and that is management of an injury that happens at the work site. The rehabilitation model is the oldest model that insurance carriers have been using. It became prominent in the 1970s, primarily as damage control.

But the emphasis changed over time. I think now within the realm of worker's compensation the emphasis is much more focused on a return to work and the vocational aspect of case management, and as we move forward to today, worker's compensation is really now getting involved in the medical realm of case management.

One of the problems, from a case manager's perspective in doing rehabilitation management, is that it has a very narrow focus. When I talk to my colleagues who are in worker's comp case management, what I hear is that they get so tired of managing lower back pain and chronic pain cases that they would like to have some variety in their case loads. So they are very interested in adding the medical component to what they do.

The next model is the catastrophic model. That's the model I'm most familiar with coming from the group health side of insurance benefits. The catastrophic model grew up in the '80s and it was the response of employers' frustration with growing medical costs particularly when they looked at the cost of catastrophic claims. Catastrophic claims represented, say, two to four percent of total claim experience but 40 percent of claim dollars.

That is significant. And they saw case management as one way to control these claim costs and it has proven to be very successful and it has opened new doors of opportunities for those of us in the healthcare profession. It is much more diverse than worker's
comp or rehabilitation case management because it includes not only traumatic injuries, spinal cord injury, but also many of the complex medical problems that we face today, AIDS.

I think you heard previously about the cost associated with AIDS and the time, the lost work time associated with that condition, managing metastatic cancer patients, managing high risk pregnancies. So the case management purview has been broadened considerably in the catastrophic realm.

One of the differences between the rehabilitation model and the catastrophic model is that in worker’s comp case management is mandatory. The individual does not have a choice as to whether or not they want to participate.

In the catastrophic model there is a choice and it is tied to healthcare benefits and the individual is asked whether they want to participate. It is more of an advocacy approach. Most individuals, from my experience, do not refuse, although initially there might be some resistance because they’re dealing with, say, a diagnosis of AIDS or cancer and they really turn inward. But eventually they do agree to participate in the case management program.

The next model is the long term disability model and the focus of this model is on vocational rehabilitation, emphasizing job accommodation. Participation here, I wouldn’t call it mandatory or voluntary. I think it’s motivational because one of the drawbacks of long term disability, particularly from the case manager’s perspective, is that the entry is at a very late point in time.

It’s much after the disability has occurred. You have individuals who have been receiving their income replacement checks, and they may have had some rehab but it may not have been as intense as a rehab program that’s focused on getting an individual back to work.

So this is really a difficult case management model from a case manager’s perspective. The other difficulty with this model is that it only focused on income replacement. The case manager does not control the medical cost side of this model therefore, the case manager cannot really initiate much in the way of treatment options and so on.

And the fourth model is the medical model. I think that’s the latest one that has come on the scene and that’s the one that there is not a clear line as to whether it falls within the realm of utilization review or whether it falls within the realm of true case management. Probably it falls somewhere in between that the focus is on cost containment from both the employer’s and the carrier’s perspective or the claim payer’s perspective. And the emphasis is on short term medical management with, today, negotiation being a driving force.

So case manager’s is addition to learning to identify appropriate services, coordinating these services, they’ve had to add a new skill to the complement of case management and that is they have to be negotiators. And this is particularly important as we have seen the growth within the alternative care market. Depending upon whether medical case management is tied to utilization review programs or whether it is within the realm of case management, it can be either mandatory or voluntary.

There are some gaps here and the one gap that I have seen in case management is that we have not addressed the short term disability piece of this. In order to manage an individual’s disability from the point of onset through rehabilitation through possibly long term needs and eventual return to work, from my perspective we’ve got to build a short term disability model. I think when you get into true disability management, this piece of it will have to be factored in.

Now, specific to disability management, I think where we need to go is a blending of these four models to include the short term disability side. So I’d like to talk now about the opportunities that I see in blending these models and the challenges that that presents, not only to the case managers, but I think to carriers and to employers.

From an employer’s perspective, they view case management in a very positive way. They have had successes with case management, I think it’s the one cost management tool that has been implemented over the past ten years that companies feel they can put their hands around.

They can actually define results, and they can see changes in their bottom lines. They can see that case management has indeed lowered their catastrophic costs. But they’re still faced with rising health benefit costs. In preparing for the report, I looked at some statistics and this is what I found, that in 1993 the average health coverage cost per employee was $5,871 and I had difficulty in finding statistics related to the average payroll cost of disability income.

The source for the 1989 average, eight percent of payroll and $2,270 per employee, is from the 1992 annual review of disability management and this is a publication that’s put out by the Washington Business Group on Health and the Institute for Rehabilitation Management. They have additional statistics in that publication so I would say that that might be a good source if you’re looking for some statistics on loss due to disability.

Also in today’s world there are no reliable estimates of individuals with disability. I think the passage of the ADA in 1990 certainly has opened up employment for individuals with disabilities. So employers are really viewing case management as a very attractive way to manage their losses from the health benefit perspective and the disability perspective. So they’re looking to the experts in the field to come up with a way to do this.

So what can case managers do? From a case management perspective, there are opportunities also. Case management can help employers control the drain on their resources and revenues. They can help reduce lost work time. Most people want
to work, they don't want to be a burden on their employer, they
don't want to be a burden on society. And case managers can be
very effective in initiating an individual's return to work.

Case managers can help reduce health benefit costs, particularly
if there is early and appropriate intervention. Case managers
can reduce the time and the cost that companies and carriers
spend in investigating disability claims and administrative costs.

Very often a company will have their human resources people
involved in the management of disability costs. They will have
risk managers involved. Then you have the carrier's various claim
adjusters involved. You may have involvement from a health
benefits side, from a disability side, both long-term, short-term,
different carriers involved. This can be a nightmare just trying to
bring everything together so that you know what's happening.
A case manager can be the individual that ties this all together.

Case management can also reduce litigation loss. Workers view
case managers as their advocates. Case managers help individu-
als through the healthcare maze. Healthcare today, as you're
well aware, is very confusing, particularly the technology that is
available. It helps individuals make better and informed deci-
sions about their healthcare needs and the options available.

Case management, I think, offers opportunities that go outside
the realm of case management, offers opportunities to insur-
ance carriers to develop new product lines and new services. By
blending case management over a variety of product lines, for
example, a carrier might blend their health benefits with short
term disability and long term disability if they're a multi-line
carrier. This will afford early intervention. Early intervention is
the key to successful case management and I will stress that over
and over again.

Blending the case management models across product lines can
bring about the integration of medical and disability costs. This
I think has been the greatest challenge to managing disability
because we're talking about two very different types of cover-
age. One pays healthcare, medical costs and the other is income
replacement. So the two need to be brought together.

Blending case management and the various coverages will bring
us the continuity needed from the onset of the disability, the
time it happens, to case closure. It will also I think result in
greater satisfaction from the employer's perspective and from
the individual's perspective and also from the professional's per-
spective. It gives an opportunity for those of us in the profes-
sion, those working in the insurance field and those working
with outside providers and vendors, to be collaborators.

This type of integration will bring a collaboration between medi-
cal, occupational and vocational providers. For the first time
providers will be talking to each other and I think you're prob-
ably well aware with the providers that you deal with that, if you
have a number of physicians involved on a case, they may not
be speaking to each other. There may be so many consultants
involved that nobody knows what is going on and that is harm-
ing the individual and that is driving up cost and certainly not
getting us to the outcome that we're looking for.

Disability case management also presents some enormous chal-
 lenges. From a larger perspective the challenge that carriers are
facing is integrating the various programs and coverages.

I think there is another component to the integration. There are
a variety of case management networks and systems. Some of
them focus on worker's comp management. Some of them focus
on group health management, and now there are many provid-
ers coming on the scene that are focusing on disability and in-
come management. So it's bringing all of these entities together.

We do not have systems that interface with each other. Our com-
puter systems don't talk to each other. When you think about
managing disability claims across the continuum, you have got
to try to bring systems that pay for health claims and systems that
pay for disability management or disability claims. You have to
bring those together. That is a difficult task.

Another challenge facing those of us involved in case manage-
ment and those of us involved in developing products is inte-
grating mandatory and voluntary programs. Do they become
mandatory? Do they become voluntary? Where do you draw the
line and where will the risk be in the cut between mandatory
and voluntary?

Then there is another issue particularly within the realm of man-
aging worker's comp claims and that is complying with state
 regulations. The regulations vary state by state, but the state
legislatures are also very closely looking at regulating managed
care. Many states have requirements or laws that require a utili-
ization review organization to meet their legislative requirements.
They must become certified with the state. So that puts another
glitch in our challenge of managing disability claims.

I stated that we need to blend case management models. While
that presents an opportunity for those of us in the case manage-
ment field, that presents also an enormous challenge to how do
we go about integrating models.

First of all, who are the qualified case managers that can manage
a case across all of these various coverages and also handle the
medical component, the occupational component and the voca-
tional component? Which discipline will take precedence? Which
discipline will be involved? Will it be one case manager
or will it be several case managers? Will there be handoffs through-
out the process?

At this point I think the nursing discipline is the most prevalent
in the field of case management but there are other disciplines
as well. There are social workers, there are rehabilitation man-
agers, vocational counselors and so on. The list goes on.
Case managers will have to develop multiple skills. In the catastrophic vein we tend to use specialists, people who are familiar with rehabilitation, people who are familiar with managing AIDS and cancer claims. So these people will have to develop multiple skills. We'll have to train those worker's comp nurses who have been dealing the backs and chronic pain to learn how to deal with complex medical situations. So I think there will be some turf war issues that we'll have to overcome.

There also are multiple players. We have claimants, families, attending physician, other providers, managed care networks and of course, the lawyers are always looming in the background.

Another challenge, and we haven't even begun to address this, is setting outcome goals and benchmarks. Will we use medical benchmarks or vocational? At what point and how often? How do we measure outcomes? I would say that today we do not have outcome measurements for disability. What should they look like? How do we define a saving methodology?

There is no consistent methodology that I know of within the models that I'm familiar with. We have to identify a data collection methodology and where we draw that data from. Also how do we measure outcomes? I would say that today we do not have outcome measurements for disability. What should they look like? How do we define a saving methodology?

One solution that has come on the scene is the 24 hour product. It's a good concept. I've done a lot of reading about it. What I am finding is that there are different opinions about what it is, how it should be approached. So I think it's going to be a different concept to put into practice.

Again we're dealing with separate claim systems, we're dealing with different carriers for each coverage. This is an attractive opportunity for those carriers who provide multi-line products. There are broad differences in product design and components and we have now the segmented managed care network.

So bringing those all together is a monumental task for those companies that are involved in developing 24 hour products. But one link seems to be a constant between all the 24 hour product development and that is case management, because it is the conduit that can lead us to early intervention.

Case management can bridge the gap between the benefits and the managed care networks and case management can also lead to development of outcome measures and the results. We've had little experience with case management but we have had some cases. My own experience really comes from my company's perspective because we have the good fortune to cover both the medical, the short term and the long term disability benefits.

Let me give you one example. This is an individual who had a head injury and he sustained his head injury, secondary to a motor vehicle accident. The medical case manager worked closely with the hospital to transition the patient promptly to a subacute facility and then to a more intense rehabilitation program.

While the patient was receiving care at the facility, the medical case manager worked closely with the employer to learn the types of work required of the patient on the job, so that this could be incorporated into his rehabilitation. The case manager also worked closely with the co-workers of the patient to educate them to the patient's deficits and needs. The patient worked as an actuary and required a high level of cognitive functioning. The case manager arranged light duty, reduced hours for the patient's initial return to work and the patient was able eventually to return to full employment.

Another situation is much closer to home. One of my case managers, last year, had a severe ankle fracture for which she required I think about nine pins in her ankle. As a result she could not work. So we arranged for her to work out of her home. And when she came back to work, we also arranged for her to take time off to go for her physical therapy treatments.

So what I am saying is that management of disability claims requires flexibility on an employer's part and a commitment of the carrier to work with the case managers to make it happen.

Finally, I'd like to close with the medical director's role. I have to say to you that this is really coming from my own perspective. In the ten years that I have been involved in case management, medical directors have not been as actively involved as I think they could be.

So I think we need to work together. We need to become colleagues in this fast growing activity of case management. From your perspective I think listening to an expert in the field of case management -- and I acknowledge Dr. Baker for inviting me to this conference -- so this is one way for you to start to learn about case management. Become a case management advocate. Case managers have to rely on medical consultants to help them understand the complexity of healthcare, understand new technologies that are coming upon us day to day.

We can't know everything. So from a clinical perspective we rely on our medical consultants that we work with. Become a consultant on both the medical and the occupational issues that are involved in disabilities.

And then finally, I would say spread the word among your colleagues that case management works for the claimant and the carrier. I don't have any solutions to how we go about bringing the case management models together, but I think the possibilities are boundless and case management certainly is a viable disability management tool. Thank you for your attention.