HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

INSIDE

RELIAS MEDIA

OCTOBER 2019 Vol. 27, No. 10; p. 109-120

Health System Reaches ED Visit Reduction Goals by Focusing on Frequent Users

Drop of more than 25% in readmissions

By Melinda Young

A national Medicare demonstration project resulted in dramatic reductions of avoidable admissions in the ED of a New York City hospital. The program used a case management approach for frequent users.

"We're a high-volume Medicaid provider," says **Larry K. McReynolds**, executive director of Family Health Centers at NYU Langone in Brooklyn.

The health system was part of Delivery System Reform Incentive Payment (DSRIP), which is a five-year, federally funded demonstration project sponsored by the Centers for Medicare and Medicaid Services (CMS) and administered by the New York State Department of Health. It ends in 2020.

> THE CHIEF DSRIP GOAL WAS FOR HEALTH SYSTEMS TO REDUCE AVOIDABLE HOSPITAL USE BY 25% BETWEEN JULY 1, 2014, AND JUNE 30, 2019.

The chief DSRIP goal was for health systems to reduce avoidable hospital use by 25% between July 1, 2014, and June 30, 2019. *(More information on the project is available at: http://bit.ly/2OVbJm6.)*

According to the DSRIP performance dashboard available only to the New York performing provider systems (PPS), NYU Langone is one of two New York systems that already has achieved the statewide goals

Financial Disclosure: Author **Melinda Young**, Author **Jeanie Davis**, Editor **Jill Drachenberg**, Editor **Jonathan Springston**, Editorial Group Manager **Leslie Coplin,** and Nurse Planner **Toni Cesta**, PhD, RN, FAAN, report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

HOSPITAL CASE MANAGEMENT

Hospital Case Management™, **ISSN 1087-0652, is published monthly by Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468. Periodicals postage paid at Morrisville, NC, and additional mailing offices. POSTMASTER: Send address changes to *Hospital Case Management*, Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468.**
GST Registration Number: R128870672.

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421.
customerservice@relias.com
ReliasMedia.com
Hours of operation: 8:30 a.m.- 6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

MULTIPLE COPIES: Discounts are available for group subscriptions, multiple copies, site licenses, or electronic distribution. For pricing information, please contact our Group Account Managers at groups@reliasmedia.com or 866-213-0844.

Back issues: $78. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date.

ACCREDITATION: Relias LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Contact hours [1.5] will be awarded to participants who meet the criteria for successful completion. California Board of Registered Nursing, Provider CEP#13791.

This program has been pre-approved by The Commission for Case Manager Certification to provide continuing education credit to CCM® board certified case managers. The course is approved for 1.5 CE contact hour(s).

The target audience for *Hospital Case Management*™ is hospital-based case managers.

This activity is valid 36 months from the date of publication.

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

AUTHOR: Melinda Young
AUTHOR: Jeanie Davis
EDITOR: Jill Drachenberg
EDITOR: Jonathan Springston
EDITORIAL GROUP MANAGER: Leslie Coplin
ACCREDITATIONS MANAGER: Amy M. Johnson, MSN, RN, CPN

EDITORIAL QUESTIONS
For questions or comments, call Jill Drachenberg at (404) 262-5508.

of reducing potentially preventable readmissions by 25% or more, says **Kris Batchoo**, assistant director of DSRIP operations and reporting at NYU Langone Health. "We were the best performer in the state for that measure," Batchoo adds. The health system also reduced ED visits by greater than 25%, he adds.

The New York State Department of Health still was evaluating data from the 25 systems participating in DSRIP through late August, and was unable to provide unpublished comparison evaluation information to *Hospital Case Management*, according to an email from **Jeffrey Hammond**, public information officer.

With an estimated 120,000 Medicaid patients, the health system first conducted a community needs assessment and found that its chief focus areas were diabetes, asthma, HIV care, behavioral health, and smoking cessation. The NYU Langone Brooklyn Performing Provider System includes the Family Health Centers at NYU Langone and more than 200 primary care providers, mental health centers, and other providers. "We built those projects into our DSRIP program," Batchoo says.

Soon, NYU Langone developed a patient navigation center and focused on identifying frequent users, the people who returned repeatedly to the ED within the previous 12 months, Batchoo says.

With greater focus on case management of that population, the theory was that the frequent users could be kept healthier and out of the hospital. "Once we knew who our high-utilizer patients were, we identified their barriers to health compliance and provided them with more targeted case management," McReynolds says.

Case managers helped identify their transportation needs and other barriers to outpatient appointments, he says.

They learned, as many case managers have, that targeting patients placed in groups according to their disease or health issue does not work as efficiently as looking at frequent users through the filter of a holistic health perspective.

"In the past, a lot of projects we worked on involved dealing with patients in a clinical category, and that was too limiting," McReynolds says. "What we found in looking at people who were high utilizers was that it was diabetes with depression, whereas in the past we looked just at diabetics or just at depressed patients."

Seeing patients according to their behavior, such as frequent use of the ED, helped the medical team to see a patient as a whole person with

EXECUTIVE SUMMARY

When a five-year, federally funded demonstration project began in New York, the goals were lofty: reduce preventable readmissions by 25% or more. NYU Langone Health achieved this goal through identifying frequent users and working with them through a targeted case management approach.

- The first step was determining barriers to health compliance.
- Next, the program integrated behavioral health into clinical care settings.
- The process also included an outreach team that contacts frequent users by phone or at their homes.

multiple chronic disease issues, he adds.

"This led us to integrating behavioral health into clinical care settings," McReynolds says. "Previous to DSRIP, all behavioral health was done at one large clinic; now, behavioral health professionals are in all clinic sites and the hospital."

New York was leading the way with a federal waiver and redesign of the Medicaid program in an effort to move away from fee-for-service to value-based reimbursement. As part of this effort, the state mandated a behavioral health project, Batchoo explains. "That was an area the state wanted to focus on, and we have a behavioral health work group," he says. "We work with partners across the spectrum to identify behavioral health needs and to put processes in place to move the needle on district performance measures."

The processes included an outreach team. Community health workers contact frequent patients via phone or in person. Their goal is to engage with patients and learn more about their underlying issues, including social determinants of health, Batchoo explains.

Community health workers then share what they learned with case managers and other professionals, who work to overcome those access and health barriers.

Often, the most pressing need among these patients is housing, McReynolds says. "Or maybe they don't have enough food for the next two days," he adds. "We found out that addressing just their clinical needs often doesn't work if the patient feels there is a more pressing need that is more important to them."

The case management goal is to address patients' needs holistically. "We find out what are the patient's needs and what does the patient see as a priority," McReynolds explains. Making this change has resulted in a greater percentage of patients keeping their doctors' appointments, he adds.

Case managers also contact community-based organizations to find resources for patients. They connect patients with primary care physicians and federally qualified health centers with sliding income scales that make patients' primary care affordable, he says.

If a patient qualifies for food stamps, case managers could see if the patient also qualifies for housing, medication assistance, or other social programs, McReynolds says. "We can make it as easy as possible for people to get all of the subsidies they are eligible for, and that builds trust with patients," he notes.

One of the common refrains the health team heard from patients was that they were assessed and then got a referral, which meant they had to travel to yet another office, and good luck with that, McReynolds recalls. The new case management approach means closing the loop. Case managers and social workers help connect patients with an agency and stay with them through the application process until they receive the resources they need, McReynolds says.

"We even give them food from our food pantry if they are that much at risk," he adds. "People need food, transportation, a doctor, and not just a name and number to call."

Walking patients through the referral process and putting them directly in touch with services and primary care providers has made all the difference in the program's positive outcomes, Batchoo notes.

"To achieve a 25% reduction in avoidable hospital use, you have to engage patients and providers and make sure you have the right strategy," he says.

McReynolds had experience with running a federally qualified health center, and he knew a key component of success in reducing admissions is to identify the sicker patients and get them quicker access to healthcare.

"We made sure any high utilizer received a needed appointment within seven days. If they needed an appointment the next day, we would help them get it," McReynolds says. "We made our schedule more flexible to get them in, and it worked great, helping us get bonuses for improving our quality," he adds. "It's dramatically improved the quality from the plan's perspective, which eventually will help us do a shared-savings model in the future." ■

Not All Capitated Payment Models Work

Align incentives with quality care

By Melinda Young

Nearly a decade ago, Maryland experimented with a global budget payment model for rural hospitals. The plan was to give them a set amount of money, called Total Patient Revenue (TPR), to improve their efficiency.

But it did not quite work out.

"The hope was, and it was maybe naïve, that rural hospitals would concentrate on efficiency and keeping people out of the hospital," says **Bernard Black**, MS, JD, professor of law and finance at Northwestern University at Evanston and Chicago.

The hospitals were told that if they provided more services, they would not receive additional reimbursement. If they performed fewer services, up to a point, they were rewarded for their efficiency, he explains.

"If they reduced costs by 5%, then they got an automatic price increase the next year," Black says. "Did they have incentives to concentrate on efficiency? Sure."

'Be Really Careful With Incentives'

ED visits dropped 12%, and non-ED admissions declined 23%.[1] But there was little incentive for the hospitals to collaborate with community providers to improve patients' health. Instead, the hospitals just reduced overall services.

"You can't just shut your emergency department," he says. "But you can make it less convenient, not well-staffed, and that's consistent with what we found — the emergency department visits dropped by a little bit."

Hospitals have control over other services, including scheduled surgeries, direct hospital admissions, outpatient hospital clinic visits, and procedures in hospital-owned outpatient surgery settings. Researchers found that these services declined rapidly over the first few years of TPR's implementation. Ambulatory surgery center visits declined 45%. Outpatient clinic visits fell 40%.[1]

The study also showed that Medicare spending increased overall in these regions, which suggested that people were discouraged from seeking services at the TPR hospitals, but sought healthcare services in non-TPR settings.[1]

"The message here is you have to be really careful with your incentives," Black says. "A well-meaning, but blunderbuss, regulatory agency thought, 'If we just give them incentives to be more efficient, they'll be more efficient, and of course they wouldn't turn patients away.'"

Yet, the TPR hospitals did turn patients away, and those patients still used Medicare dollars to receive help from other providers. "The big picture here is that people were not deprived of healthcare, and we did not reduce the need for healthcare — there's no evidence of that," Black explains. "The care was moving outside the capitation area of rural hospitals."

Maryland's quality measures, which could have served as a check and balance on the capitation model, only measured what the hospital was doing for patients inside the hospital. It did not look at how the patients were performing overall in their health and in other health settings, Black adds. This type of economic pressure can be anticipated when the payment model is poorly designed.

"Say the hospital is capitated, and everything else is fee-for-service," Black says. "There's incentive to push things out from under capitation to the fee-for-service world."

Accountable care organizations (ACOs) operate differently because they cover their populations' care in all settings. "ACOs are a hard way to make money on the provider side," Black says. "If you have all of those patients, the tradeoff is that if you provide them with less care, you will make more money today, but get a bad reputation and have fewer patients tomorrow."

Hospitals that are part of an ACO have a strong incentive to provide efficient and high-quality care, he adds.

The study's takeaway message is that alternative payment models should not leave holes. "They have to be full capitation or be really smart and clever and on top of the incentives," Black says. "If you're fighting people's incentives, the incentives will win." ■

REFERENCE

1. Pines JM, Vats S, Zocchi M, Black B. Maryland's experiment with capitated payments for rural hospitals: Large reductions in hospital-based care. *Health Aff (Millwood)* 2019;38:594-603.

Program Targeting Patients With Diabetes Reaches A1c Goals

Patients greatly improve quality of life

By Melinda Young

A rural West Virginia pizza shop owner and grandfather found his long work days punctuated with fatigue. He visited his doctor and was diagnosed with diabetes. His A1c (glucose) level was between 11 and 12, twice the optimum level.

"He had multiple people relying on him to be successful," says **Megan Adelman**, PharmD, a clinical pharmacy specialist with the department of family medicine and an assistant professor at the West Virginia University (WVU) School of Pharmacy.

The man was referred to WVU School of Medicine's diabetes team-based program. Within six months, his A1c dropped to below six. "He lost weight and was almost a nondiabetic, and he didn't have the pain and fatigue he had when diagnosed," Adelman recalls. *(For more information, see related story on page 114.)*

Overall, the diabetes care program helped patients lower their A1c levels from an average of 10.25 to an average of 8.7 within three to six months, says **Dana E. King**, MD, MS, professor and chair of the department of family medicine at WVU Medicine.

Even at 18-month follow-ups, 86% of patients recorded lower A1c levels than they did in the beginning, and one-third of patients registered A1c levels below 8, he adds. "The clinic model was effective in having a positive impact," King says.

Data about hospitalizations and ED visits are unavailable, he notes. "We need to do this program for several hundred patients to get significant results," King explains. "After the clinic has been going on for a little longer, we might get longer-term outcomes like hospitalization rates or amputations."

The team-based diabetes care program started as a quality improvement initiative. Practitioners were concerned about the patients who could not control their diabetes. Through brainstorming, they came up with the team-based approach. A team could determine whether a patient's issues are related to the medicine, access barriers, mental health issues, or other problems, King says.

"We said it could be any of those things and was probably multifactorial, so we started this Thursday afternoon intensive diabetes clinic for people in our practice," King says.

The clinic is run through the department of family medicine, corralling all resources within the department, he adds.

The following is how the intensive diabetes clinic works:

• **Form a team.** The diabetes team includes a resident physician, a pharmacist, a registered dietitian who doubles as a certified diabetes educator, a psychologist, and a nurse care coordinator.

"The team provides multifaceted care," Adelman says. "I love working with an interdisciplinary team because this is where we get a lot of breakthroughs. Our patients know who we are, and we're able to motivate them, so they feel empowered about their care, which is so gratifying."

• **Reach out to patients.** The nurse care coordinator calls patients two or three days before their visit to remind them to come in for a visit with the team, King says.

"The nurse triages any acute issues that come up," Adelman says.

• **Play assessment musical chairs.** Patients see each member of the team, starting with the diabetes educator/dietitian, who finds out how the patient is doing with diet, exercise, and lifestyle.

The psychologist and pharmacist meet separately with the patient. While one professional is meeting with a patient in room A, another person is meeting with a patient in room B, and they rotate for efficiency. For instance, the psychology team might talk with the patient about anxiety and depression, and complete an assessment of the patient's mental and emotional state, King explains.

"Sometimes, that's a big focus of the visit, and sometimes it's about making behavioral changes and working through barriers," he adds. "Then, the pharmacist comes in and does an assessment of medications and side effects."

The dietitian might tell the patient, "You need to eat fruits and vegetables every day and not just on the weekend," King says.

"Patients are there for an hour-long visit, and we're playing musical chairs with the rooms," King says. "Then, they come back and huddle

with doctors for a few minutes to give them a summary of what they've learned."

Each team member does everything they can to listen to the patient and to identify issues within 15-minute increments, Adelman says. "I talk with patients about medication that is feasible, manageable, and affordable for them," she says. "We discuss multiple aspects of care in terms of stress," she adds. "The psychology team member might say the person needs more intensive therapy."

After hearing the summary, the physician visits the patient to talk about changes the patient can make to improve overall care.

• **Provide follow-up.** Patients return in a month for a similar visit with each member of the team. Each month, the patient's A1c is measured, and the plan is adjusted. "It's the same routine," King says.

Also, each discipline has a student following and meeting with the patient, he adds. "This is a model that you could do in rural settings," King says. "Within a whole community, there is a pharmacist and behavioral medicine person, and maybe a diabetes educator." ■

Case Studies Offer Clues to How Team Case Management Model Worked

A man in his 40s had recently received a diabetes diagnosis. It was tough news to hear because he was a single father of three children, and he worked full-time.

"He had severe fatigue, and his kids ranged from seven to 15," says **Megan Adelman**, PharmD, a clinical pharmacy specialist with the department of family medicine and an assistant professor at the West Virginia University (WVU) School of Pharmacy. "He wanted to be a part of his kids' lives, but was having a hard time keeping up with them," she adds.

WVU School of Medicine helped form an intensive diabetes clinic, designed to help the highest-risk patients with diabetes improve their health and habits. The man started coming to the clinic for focused attention.

The patient's life had taken a stressful turn recently when his wife left him and the children. The father was not surprised by the diabetes diagnosis because his family had a history of problems with the disease. Diabetes had led to kidney disease and multiple skin infections for some of his relatives.

"He said, 'With everything going on in my life, I knew this was inevitable,'" Adelman recalls. "He wanted to start insulin, and he wanted a quick turnaround."

The diabetes team worked with him to lower his glucose levels and improve his health habits. Insulin helped, as did the team's focus on his stress levels and self-care motivation, she notes. "He felt empowered and wanted to be there for his kids," Adelman says. "When we were talking about goal setting, he said, 'I have to take care of these kids, and I want to live to see grandkids.'"

The patient needed to improve his diet, even as he faced the obstacle of having three children to feed. "His diet was focused on what his family could eat, so he began to teach his children healthy lifestyle choices. He told them that he was trying to get healthier so he could be healthy for them," Adelman says.

The easy part was increasing his physical activity because his children were very active, she adds. "There was a lot of chasing them around, going on hikes, kicking the ball around," she says.

Within six months, the patient's A1c level decreased from greater than 10 to single digits. He lost weight every week, Adelman says.

In another case, a pizza shop owner, who had spent much of his time eating his own pizzas and other Italian food, developed diabetes and chronic kidney disease. The man was adamant about not receiving insulin, even though his A1c level was between 11 and 12, Adelman says.

The team listened to him and came up with an alternative strategy to lower his blood glucose levels. It required great discipline. "This case highlights how we're not a compliant-driven or physician-oriented clinic; we're a holistic clinic, where the goals of patients drive our care," Adelman explains. "It would have been easy to say, 'You're going on insulin,' but we said, 'If your A1c doesn't come down, then we feel like you'll have to go on insulin to make sure you're not hurting your organs.' We started him on oral medications that are appropriate to start if you have kidney disease, and we asked about what other lifestyle changes he could do," Adelman says. "He was active in self-care and goal-setting. He didn't want to go on insulin because he bought into the lifestyle changes."

The patient changed his diet. He still ate at his restaurant, but stuck to

salads and consumed far less pizza. He also set realistic exercise goals, including walking three times a week for 20 minutes. Later, he increased to walking five times a week.

"These small, incremental changes helped to make it sustainable," Adelman says. "We started slow, so he could have self-confidence."

The patient's kidney disease was a baseline comorbidity, and no one expected it to improve. But the diabetes treatment helped prevent it from becoming worse, she adds. The man lost weight and reduced his A1c to 5.8, a level that put him into nondiabetic category.

When a follow-up check-up showed that the patient's A1c level remained low, the diabetes team decided to stop one of his oral diabetes medications. Eventually, if his improvements hold, he could be taken off diabetes medication entirely, Adelman says.

"These are the kind of stories that motivate us," she adds. ■

Children With Chronic Illness: When Compliance Is Complicated

By Jeanie Davis

Children living with chronic illness often struggle with their treatment regimen. Depression and anxiety may be involved, as the child likely cannot cope. But that is just one component of the noncompliance picture, says **Adrianne Alpern**, PhD, a pediatric psychologist at Children's Hospital of Orange County (CHOC Children's), a pediatric healthcare system in California.

"Kids don't live in a vacuum," says Alpern. "Their family, their community, their school are all involved. Each part of the system contributes to compliance challenges."

Psychological and medical trauma, as well as family issues, may be involved. The child may be embarrassed, forgetful, or distracted by competing activities. In some cases, the medication side effects, taste, or regimen complexity can be barriers. Insurance coverage and access to care also play a role in compliance, she explains.

Over the past 10 years, Alpern has worked with hundreds of kids with chronic illness who are not following their doctor's orders. Compliance is complicated, she says. "The family has to do a lot. They must understand and believe in the child's diagnosis, and believe that the treatment will help," Alpern explains. "They have to understand the risk of not complying. They also have to understand the regimen, learn to use medical equipment, get prescriptions filled — and it all has to fit into their everyday lives."

The medical condition adds an extra layer of stress to childhood, she adds. "All kids compare themselves to each other, which is part of being a kid. When there's a medical condition on top of that, there's a lot of embarrassment and shame."

For example, children with diabetes frequently tell her "what a pain their treatments are, or how annoying or frustrating it is. They don't feel like doing it," Alpern explains. "They are embarrassed when they have to check blood sugar in front of friends or leave class early to see the nurse. There's a lot of singling out, so they feel separate from their peers."

That is why no one single intervention will work for compliance, she says. "We have to address this on the individual level and the family level, based on the child's age, complexity, and discomfort of the regimen, access to medication, insurance copay, and/or how far they live from a pharmacy."

Recognizing Red Flags

Healthcare providers, including case managers, must help children and parents overcome these barriers, she says. Children with asthma, diabetes, and other serious chronic diseases often are well-known to emergency providers, notes Alpern. The ED is a natural point to begin the conversation with parents. She advises case managers to know the red flags for noncompliance: parents who seem overwhelmed, a child with needle phobia, or a child who refuses to take medication.

Early intervention is key, she says. "The longer the challenges go on, the harder they are to treat. That's why lot of medical clinics are now conducting routine depression and anxiety screening. Anxiety can be just as impairing and affect adherence as much as depression."

Most of these patients have a history of trauma, including medical trauma, says Alpern. "When a child has an ambulance ride or a scary hospital procedure, or going through the process of being diagnosed, they

are at risk for medical trauma. If they see everyone around them freaked out, or see their parents stressed like never before, that can result in medical trauma," Alpern adds. "The child may think they're dying. No one is telling them what's going on; they don't know it's treatable. They can be traumatized by all of this."

Trauma contributes to avoidance, she says. "It makes people want to avoid the thing that creates the trauma. They avoid memories of the trauma, so they avoid treatment. Some kids can't think of the illness long enough to take medication because of the trauma."

Trauma-focused cognitive behavioral therapy can be adapted for children or adults who have experienced medical trauma, says Alpern. The program includes "fun elements" that engage children. She adds, "A good child therapist should be able to make therapy somewhat fun."

For hospital case managers, it is critical to look for clues that the family is struggling with adherence. Realize the parents will be guarded in what they disclose, as they have been lectured before. How providers communicate with children and their parents will affect medication adherence, she says.

"From the beginning, the language we use is so important," Alpern says. "Being truly nonjudgmental is very important so the family will continue to open up and tell us what's going on. They don't want to feel judged or blamed. They are doing the best they can."

In some cases, simplifying the regimen will help. Change a dosage from three times per day to one time per day, if possible. If the medication tastes bad, talk to the physician about switching to one that tastes better.

Do not use the word "compliant," as it sounds judgmental, she adds. "The child feels, 'They think I'm bad, they don't like me.'" Instead, describe the problem as "trouble with the medication regimen."

She advises following this approach in talking with children and families:

- "Many people find it challenging to fit their medications into their daily lives. How much does that apply for you?"
- "You have a lot on your plate. You have to balance school, soccer, and medication. Tell me about what makes it challenging to take your medicines."
- "Tell me about the last time you were not able to fit your medication in."
- Respond neutrally.

Neutral or positive response will help patients continue to be honest with medical providers, says Alpern. "If families or children feel any shame or guilt, they won't feel comfortable telling you the truth."

Giving the child choices about what is important to them is key, she adds. "You have to work with what the child is willing to do. There are ways to increase their willingness to do more with therapy over time, depending on severity and how supportive the family is." Weekly family appointments are most effective, she adds.

Find a Mental Health Professional

A case manager can help find a mental health professional who can counsel the child, says Alpern. Typically, a nearby children's hospital will employ a mental health professional who can provide therapy.

When adherence and mental health concerns coexist, there is a huge range of severity (from mild to severe), says Alpern. "Only the most severe cases would need hospitalization (in the event of life-threatening adherence), and only after several failed attempts to treat them in outpatient settings."

If the child requires psychiatric medications, the situation becomes more complex. Finding a psychiatrist who will treat a child with complex chronic illness is not easy, says Alpern.

"Concerns about drug-drug interactions, and how psychiatric medication could influence the medical condition itself, often make it difficult to find treatment for the child," she explains.

Outside of metro areas, it may be difficult finding mental health providers with experience working with children who battle chronic medical conditions, she acknowledges.

"If you don't have experts in your community, create them," advises Alpern. "Develop relationships with therapists in the community and train them in what you need, or encourage them to get training. Or, host an in-service to teach local therapists and psychologists about the illness you want to serve."

The American Diabetes Association offers training for psychologists, she adds. "Partner with therapists in the community. Tell them, 'If you go to this training, I will have a lot of patients for you.'"

Develop a simple one- or two-page handout about the medical condition and how therapists can help address the condition. Make that handout available to mental health providers in the community, and give it to each family when you make a referral.

Find out about local or regional hotlines for primary care providers and psychiatrists. Some hospitals offer psychiatry hotlines for local providers specifically to guide them on using psychiatric medication in complex cases.

"Adherence is on a continuum from more than 100% (someone who follows their entire regimen as directed or goes above and beyond the regimen) to 0% (someone who does nothing)," Alpern explains.

However, she adds, "A patient with moderate to severe depression who would benefit from psychiatric medication is still *very* different from a patient who would need to be hospitalized for 90 days."

Some states and counties offer "wraparound programs" in which outpatient therapy is supplemented with in-home services, Alpern explains.

Case managers also could send inquiries through local and national listservs to find out more about resources, she advises.

Is Hospitalization Necessary?

Inpatient hospitalization is considered in the event of life-threatening adherence concerns and in the most extreme cases, says Alpern. "If a patient has life-threatening adherence issues and is at risk of immediate serious complications in very extreme cases, a few programs offer intensive 'partial hospitalization programs' in which kids spend most of the day there and then go home to sleep," she explains. These programs generally accept children with chronic conditions and psychiatric needs.

In an emergency, an inpatient psychiatric unit located at a medical center may be able to admit the patient or provide guidance on referrals, she adds.

Cumberland Hospital for Children and Adolescents, located in New Kent, VA, is a general hospital with a certification in behavioral health and development. The hospital treats patients between the ages of 2 and 22 years with co-occurring medical and behavioral issues — such as diabetes, Crohn's disease, sickle cell anemia, disordered eating, neurobehavioral issues, and morbid obesity — along with depression and anxiety. Average length of stay for this inpatient program is 120 days.

Cumberland Hospital also provides a residential treatment center for children with psychiatric issues who also may have medical diagnoses. Average length of stay for this program is six months to a year. Cumberland's multidisciplinary approach helps create a lifestyle change in the child, says **Alan Tager**, Regional Clinical Liaison for the hospital.

"We receive med/psych referrals from all over country for children that have co-occurring medical and psychiatric issues," he explains. "Medical hospitals do not want the behaviors, and psychiatric facilities are unable to manage the medical complexities. We stabilize their med/psych issues simultaneously, treating the child and providing education to the family so there is a smooth transition from our hospital to the home."

Family therapy plays a significant role in outcomes, Tager says. "Many times, there are issues that are happening in the home that is on the mind of the child. The child does not have the coping mechanisms to manage the stressors. Hence, behaviors are projected both outwardly and/or self-injuriously. Family therapy helps bring these issues to the surface to create a pathway for healing."

Tager cites data on children with Type 1 diabetes who are admitted to their facility for noncompliance. Outcomes studies show a 100% improvement in diabetes regimen adherence following 90 days post-discharge.

"There are no emergency room visits or admits related to diabetic ketoacidosis in our patients who complete the program," says Tager. "Providers who refer patients to the hospital are invited to participate in treatment team meetings. They will receive monthly reports from each hospital discipline. Appointments are made prior to discharge so the child will go back to the local provider of care in their hometowns."

Alpern believes a truly successful program must involve the family in face-to-face counseling sessions. She also believes that "inpatient care is simply not necessary for most children," she adds.

"Most children with adherence challenges do not need inpatient care; only the most extreme cases require that type of program," Alpern explains. "Many patients with adherence concerns and mental health needs can be successfully treated in outpatient settings if you can find the right provider."

She also cautions against focusing solely on depression as a cause of noncompliance. "We cannot put this entire problem on depression. For this reason, we need an individualized approach to treating patients with adherence challenges. It's not just about the person; it is about understanding the entire system around them."

Health insurance and Medicaid will pay for the child's mental health counseling and family therapy. "If the child needs weekly therapy and is at risk for unnecessary hospitalization and irreversible complications from illness, we can justify providing this higher level of care," says Alpern.

She is hopeful for children and their families. "They are generally resilient; sometimes, they just need someone to help bring out their strengths." ■

Intensive Inpatient Rehabilitation: Optimal Path for Stroke Patients

By Jeanie Davis

After acute care, a stroke patient's discharge plan should include an inpatient rehabilitation facility (IRF) when they meet specific medical criteria, according to the 2016 American Heart Association/American Stroke Association guidelines.

Stroke also tops the CMS 13 list, which designates 13 medical conditions that 60% of an IRF's patients must have for the IRF to qualify, says **Dina Walker**, RN, MSN, ACM, RN-BC, National Director of Case Management for Encompass Health. *(The CMS IRF fact sheet is available online at: https://go.cms.gov/30FJeKA.)*

IRFs provide hospital-level care to stroke patients who need intensive, interdisciplinary rehabilitation care provided under the direct supervision of a physician. The benefit of an IRF, says Walker, is the team's high level of accountability and specialized training to care for the complex needs of stroke patients, including skin care, dysphagia, management of spasticity, depression/anxiety screening, progressive and intensive training in mobility, and activities of daily living (ADLs).

"In an inpatient rehabilitation setting, patients have physical, occupational, and speech therapies available to them for intensive therapy," she explains. "It's not unusual for stroke patients to require all three therapy disciplines. The overall goal is to improve the patient's function and prepare the patient and their family or caregiver for return to home and back to the community so they can get back to doing things they enjoy."

Outcomes data drive the treatment planning, which guides patients toward optimal recovery, Walker explains. A team approach to goal-setting involves the patient and family starting on day one. When discussing goals, the therapists relate the goals to the specific treatment or exercise so it is more relevant to the patient.

"Our therapists and nurses are excellent coaches, constantly cheering the patient on, reminding them of progress made from day to day," says Walker.

Weekly team conferences, daily physician visits, and routine visits by a physician are in the patient's treatment plan. Top priorities are bowel/bladder, pain and spasticity control, and intensive therapy to help patients improve their functional abilities and mobility.

Appropriate use of pain medication is a focus to avoid side effects, including oversedation, constipation, urinary retention, and potential addiction. The team may use alternative pain treatments such as repositioning, frequent rest breaks, identifying the appropriate equipment, mindfulness, and possibly holistic measures such as acupuncture. Spasticity is addressed with specific medications (yet avoiding side effects), and using movement, Botox/phenol blocks, and orthotics.

Patients undergo physical, occupational, and speech therapy every day, depending on how much therapy they can tolerate, explains Walker. CMS requires three hours of therapy five days a week. "Inpatient rehab is pretty intensive, so the patient should be willing and able to participate in rehabilitation," Walker adds. "If the patient is especially debilitated and cannot tolerate the five-day schedule, the therapist may recommend stretching the therapy regimen over seven days instead of five so it is not too intensive in the very beginning of their stay. Then, as the patient's endurance improves, they can gradually transition into a more intensive program."

"Therapists are trained to deal with the cognitive and behavioral aspects of a stroke, always looking for signs that can indicate depression," says Walker. "Stroke is a perfect example where it's necessary to treat the whole person, not just the disease, because a stroke has such wide-ranging effects on the person."

Avoiding readmissions is a primary goal. Depression is a leading cause of post-discharge readmission, so the team is keyed into that. "When patients are depressed, they are less likely to take care of themselves, may not take their medicines, and this can lead to a downward spiral," she explains.

In addition, the team must identify and address risk factors for unnecessary ED visits and acute inpatient readmission, says Walker. Causes can include high blood pressure, urinary retention, dehydration, medication, skin breakdown, pneumonia, depression, constipation, falls, pain — and another stroke.

Average length of stay in an IRF can vary for stroke patients. "If the stroke is pretty severe, the team will be working on so many things with them. In general, the length of stay may be 14 or 15 days," she says. "Our hope is always that these deficits are temporary, and as their brain heals, the impacted body functions will

also heal," Walker says. "But it takes time, and it depends on the severity of stroke and where it was in the brain."

For many stroke patients, the prognosis is excellent and they can return to their lives "close to normal," she adds. "For some, recovery can take longer. Sometimes, it can take years."

Walker prefers the term "transition" instead of "discharge" planning. "Discharge implies the patient is gone and our job is done, and we just don't work that way. We are always here for them. We are always available to help, even after discharge," she explains.

She outlines the following steps in a transition plan:

• Identify the primary caregiver. "If someone hasn't said 'it's me,' you must ask," says Walker. "You can't assume the daughter will be the one to help because you've been talking to her during the hospitalization. She may be leaving town two days after discharge. You may have a gap in care at that point. Never assume, always ask: 'Will you be the one to help care for them once they get back home?'"

Follow up with: "'How long each day can you stay? Will you be there a few hours, all day, or just pop in and visit?'" says Walker. "You may identify more gaps based on these answers, and you must plan for those gaps."

• Determine any ongoing rehabilitation needs. "Be specific and prescriptive," says Walker. "You can't just have a blanket order for home health that says 'evaluate and treat the patient' because that evaluation and planning takes time. When the patient is ready to go home, there isn't the luxury of time. Those things have to be in place already, as much as possible."

• Order appropriate equipment and devices. What will the patient need for ADLs and mobility? Consult with physical and occupational therapists.

• Plan for home modifications. Does the patient have balance issues and need grabbers installed? "The sooner you get this underway, the better," says Walker. The case manager also may need to identify financial resources to cover these needs, she adds.

• Involve a social worker. Stroke patients will need someone who can work ahead of the patient's discharge. Social workers provide counseling and coaching. "We're treating the whole patient," says Walker. "Think about that stroke patient, their level of function, what their life was like before the stroke, and what they will need to regain their function and some semblance of normalcy."

If the patient stayed in acute care and an IRF, consider that this patient may have been away from home for possibly two months after an acute stroke. "That patient has the potential to be overwhelmed with their life," says Walker. "They will have stacks of bills and mail, rotten food in the fridge, might come home to a dead plant or pet. If you add all of that on top of limitations because of their disease process, that is quite overwhelming."

A social worker can help smooth the way for transition home. They can arrange any coaching, counseling, or community resources the patient will need.

• Educate the patient and caregiver on how to prevent another stroke, manage chronic comorbidities, and challenging medication regimens. "The medication regimen can be very complex, and is a huge factor to consider in avoiding a readmission," Walker says.

• Ask the home care agency for a same-day admission or admission within 24 hours of discharge. "Try to have a nurse and therapist at the home when the patient arrives. How much stress and anxiety would that alleviate for a patient and their caregiver?" says Walker.

• Set up timely follow-up appointments within three to five days post-discharge. Walker suggests coordinating care with the patient and caregiver. "You're modeling the behaviors they need to learn to self-manage their healthcare needs — how to handle those calls, how to get past barriers, the words to use, who you spoke to," Walker explains. "Don't coordinate all the care from your office; show them how to do it. It helps so much."

• Complete a care transition document for each patient. "This is a concise document that contains important details about that patient and why we think the patient is high-risk for readmission," says Walker. It includes the transition plan that the case manager has initiated, as well as key follow-up: outstanding labwork, radiology tests, or other diagnostic testing.

• Review and educate the patient and caregiver on community resources, including a stroke support group. Several Encompass Health rehabilitation hospitals are designated Stroke Centers of Excellence. As part of that designation, that IRF must coordinate stroke support groups.

"Don't just give patients a list of resources," says Walker. "Identify who could help the soonest, start the referral, and get them on the list. Many community resources have lists of people in need, so get your patient on the list as soon as possible so to minimize their wait time for services. Plead your patient's case for them and get them moved up on the list, if possible."

"Be a proactive patient advocate," she says. "Start the process right away and make the referrals." ■

HOSPITAL
CASE MANAGEMENT

CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.
2. Log onto ReliasMedia.com and click on My Account. First-time users must register on the site. Tests are taken after each issue.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the test, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be emailed to you.

CE QUESTIONS

1. **The Delivery System Reform Incentive Payment program has a five-year goal for health systems to reduce avoidable hospital use by what percentage?**

   a. 10%
   b. 15%
   c. 20%
   d. 25%

2. **A recent study found that Maryland's Total Patient Revenue (TPR) successfully met a chief goal of reducing ED visits, but showed which problem?**

   a. Hospitalization rates increased significantly at hospitals.
   b. Medicare spending increased, suggesting that people were discouraged from seeking services at the TPR hospitals and went to non-TPR settings.
   c. Hospitals made too little money to afford their population health services, despite the incentive pay.
   d. Patients died at a higher rate than did patients in non-TPR hospitals.

3. **Which is *not* a medication compliance issue for children?**

   a. Social embarrassment
   b. Regimen complexity
   c. Few incentives for compliance
   d. Bad taste

4. **Why is it important to treat the whole person and not just the disease in stroke patients, according to Dina Walker, RN, MSN, ACM, RN-BC?**

   a. Comorbidities may affect stroke recovery.
   b. Depression is a leading cause of readmission for stroke patients, as patients are less likely to take care of themselves.
   c. The whole-person approach brings relief to caregivers.
   d. Stroke patients always require at-home care.

CE OBJECTIVES

After reading each issue of *Hospital Case Management*, the nurse will be able to do the following:

1. identify the particular clinical, administrative or regulatory issues related to the profession of case management;
2. describe how the clinical, administrative or regulatory issues particular to the profession of case management affect patients, case managers, hospitals or the healthcare industry at large;
3. discuss solutions to the problems facing case managers based on independent recommendations from clinicians at individual institutions or other authorities.

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

Ethical Issues and Standards in Case Management, Part 1

By Toni Cesta, PhD, RN, FAAN

Introduction

This month, we will discuss principles related to ethics and how they affect one's role as an RN case manager or a social worker. These principles include patient advocacy, which applies to all the roles and functions that case managers perform. Patient advocacy relates to the ethical principle of beneficence. According to this principle, the case manager works with the physician and other members of the interdisciplinary healthcare team to advance the best interests of the patient and family. This ethical issue focuses on promoting the interests of others, whether it be preventing harm or improving the situation for the patient/family.

Case managers must weigh and balance the possible benefits against potential risks of an action, intervention, treatment, and decisions, especially concerning care options. They also are expected to protect and defend the rights of their patients/families and help those unable to speak or assist themselves, especially during unsafe or potentially dangerous situations. Beneficence is an ethical principle that directs the healthcare professional to promote the safety and well-being of his or her patients.

USING THE PRINCIPLE OF BENEFICENCE, THE CASE MANAGER ALWAYS SHOULD SELECT THE CHOICE THAT WILL ADVANCE THE BEST INTERESTS OF THE PATIENT AND FAMILY.

The Case Manager and Social Worker as Patient Advocate

An essential role of the case manager is patient/family advocate. In this role, the case manager may be presented with conflicting choices. Using the principle of beneficence, the case manager always should select the choice that will advance the best interests of the patient and family. Everything a case manager or healthcare professional does should be subordinate to the patient's interest. As a patient advocate, the case manager must provide patients and their families with the information necessary to make better informed decisions concerning their healthcare services and must support those decisions.

The Commission for Case Manager Certification (CCMC) describes advocacy in case management as a process that promotes beneficence, justice, autonomy, self-determination, and independence for clients/patients and their families or caregivers. It involves educating clients about their rights, benefits, and healthcare and human services, facilitating informed decision-making, and considerations for the client's values, beliefs, interests, and culture.

Case managers should balance the risks with benefits when deciding on the plans of care. They also must educate patients and families about potential undesired effects before implementing a care plan or discharge plan. Case managers in these situations can counsel and educate their patients about their options and ensure that the patient understands the risks and benefits and can make informed decisions.

For example, social workers and case managers face such dilemmas when offering patients and their families a list of post-acute choices. Some may experience better safety and quality outcomes than others. By assisting patients in making informed decisions, case managers ensure that patients understand the potential risks and

benefits for the decision to be considered ethical.

The traditional ethical ideal of the case manager as a patient advocate directs the case manager to act in ways that will maximize the best interests of his or her own patients and their families.

Ethics and Third-Party Payers

Like other healthcare providers, case managers and social workers need to adjust to the changing circumstances of managed care. This requires rethinking some of the traditional ethical ideals that have formed the profession.

The transfer of decision-making authority to the health insurance plan has, in turn, transformed the relationship between healthcare professionals, case managers, social workers, and their patients and families. Physicians are no longer in a position to freely provide their patients with all the care that might reasonably be expected to benefit them in any setting of their choosing. During the fee-for-service era, care providers could act with little concern for costs. In so doing, it was commonly thought, they discharged their duty of beneficence. But, in the current healthcare reimbursement system, the provider is at an increased financial risk due to utilization management practices of payers and value-based reimbursement. The free-handed approach is no longer a viable option.

Case managers can function as patient advocates in the following two ways:

- Ensure that ethics consults are called when necessary;
- Ensure that patients' interests are fully represented and protected in these consults.

Organizational Ethics

Case managers and social workers are more likely to encounter issues related to organizational ethics than clinical ethics. The type of ethics consult that a case manager is likely to call for differs in significant respects from the traditional clinical ethics consult. The clinical consult largely centers on how individual practitioners can best resolve ethical conflicts that arise when they are treating their patients; for example, deciding whether to terminate care or treatment. However, the conflicts that arise in the context of case management, health insurance, and managed care utilization management procedures and decisions are more organizational. In some respects, these conflicts can better be grouped under a category of "Organizational Ethics" rather than the traditional "Clinical Ethics." Organizational ethics requires the participation of those who understand systems of care, utilization management procedures, and insurance plans, rather than clinical care.

If an organization has not created an organizational ethics committee, case managers should advocate for one to assist in solving ethical dilemmas, such as those related to utilization management procedures, resource allocation and utilization, and discharge or transitional planning. Utilization management committees are not enough; they are not the best forum to address ethical concerns of an organizational nature. Organizational ethics committees must include participants who are not traditionally present in clinical ethics committees. These include experts in insurance plans and agreements, administrative processes, and systems of care.

Organizational ethics committees should be subcommittees of the organizationwide ethics committee and should report their issues and decisions to the ethics committee regularly.

Organizational ethics deal with an organization's behaviors related to the individuals represented by that organization (including patients, care providers, and other employees), the community, and other organizations. There are several different categories of organizational ethics. However, the types of organizational ethics conflicts that case management professionals must address will be limited to the unique roles that they play inside the healthcare organization. For example, the roles that case managers play give rise to the types of conflicts for which an ethics consultation would be appropriate:

- Resolving care-related conflicts;
- Preventing delays in treatment;
- Increasing and facilitating access to care and resources;
- Brokering services within and outside the healthcare organization;
- Obtaining authorizations for treatments from insurance plans and managed care organizations;
- Advocating for patients while working with insurance and managed care.

To illustrate an organizational ethics issue, consider the following case.

Organizational Ethics Consult Case Study

Mr. Gaynor was found unconscious. He was admitted to the ICU of a nearby out-of-network hospital. He remained in the hospital for six months before he was discharged to his home in another state. Two weeks later, Mr. Gaynor experienced another syncopal episode. His wife requested that the

ambulance bring him back to the original hospital. The physician from the hospital agreed that this would best serve the patient's medical and health interests. However, because the patient was "out of network," the case manager was called to decide whether the admission was appropriate.

Cases like this have become more common in an era of insurance and managed care restrictions. In this type of case, case managers best discharge their ethical responsibilities by deliberating with others to determine the appropriate response. However, the people the case manager would most likely need to consult will differ from those a physician or nurse would consult in a dilemma of clinical ethics. In addition to the patient's family, physician, and a trained ethicist, the case manager also should consult a member of the managed care department, legal department, patient relations, and social work.

Examples of Categories of Organizational Ethics

Healthcare Business

- Cost shifting;
- Billing practices;
- Financial incentives;
- Resource allocation;
- Conflicts of interest.

Societal and Public Health Considerations

- Serving the medically underserved;
- Antidumping issues (EMTALA);
- Discrimination against patients;
- Public disclosure of clinical errors;
- Guardianship.

Healthcare Advertising

- Making unrealistic promises;
- Endorsing specific medical products;
- Marketing of healthcare institutions.

Scientific and Educational Issues

- Education of future healthcare providers;
- Performing research and clinical trials.

General Business Practices/ Relationships

- Employees;
- Vendors;
- Payers;
- Outside agencies.

MANAGING CARE WITH LIMITED RESOURCES REQUIRES CASE MANAGERS TO OVERSEE THEIR PATIENTS' JOURNEYS THROUGH THE HEALTHCARE SYSTEM WITH AN EYE TOWARD ELIMINATING INEFFICIENCY AND UNNECESSARY EXPENSE.

Given the training and institutional role in today's healthcare system, case managers and social workers must develop skills for collaborating with physicians, nurses, patients, and family members on developing comprehensive and integrated healthcare delivery plans. These collaborative skills are needed to engage effectively in deliberative decision-making to resolve problems of organizational ethics likely to arise under managed care plans and the utilization management restrictions imposed on your practice.

Methods of Approaching Ethical Dilemmas

Case managers sometimes have to choose between the needs of the patients vs. the needs of the organization. This is particularly true as it relates to the balance between the cost and the delivery of healthcare services. Managing care with limited resources requires case managers to oversee their patients' journeys through the healthcare system with an eye toward eliminating inefficiency and unnecessary expense — especially from duplication and fragmentation of services. In organizations using bundled payment systems, case managers must balance the needs and interests of patients to stay within a fixed budget.

Cost containment often is disparaged as a financial rather than a medical and quality goal. This is only partly true; cost-containment techniques are essential to provide people with affordable healthcare. When case managers function within a legitimate health insurance and managed care environment to limit costs, they are not merely serving the interests of insurance companies but are serving the interests of society as well.

Below are some methods to use when approaching these dilemmas:

- Enforce and promote mutual trust among all parties involved.
- Maintain the patient's confidentiality, privacy, right to choose, and self-determination.
- Affirm the dignity and worth of each party.
- Project commitment to truthfulness.
- Respect diversity of values and

difference of opinion, including right of refusal of care.

• Ensure congruence between verbal and nonverbal communication.

• Avoid being task-oriented.

• Allow sufficient time for each ethical issue.

• Spend enough time with the patient, family, and other healthcare providers for each dilemma faced.

• Meet with patients and families in private rooms and comfortable settings.

• Believe that good communication results in desirable outcomes.

• Assume and project a sense of responsibility and accountability.

• Always involve others in shared decision-making, regarding the issue at hand.

• Deliberate with a consistent set of values and goals.

• Distinguish ethical problems from other general patient care management issues.

• Seek the assistance of others when unable to address the issue independently.

• Be thorough and timely in gathering information; value uncertainty over confidence.

• Always apply the institutional policies and procedures; they are intended to support and guide practice.

• Document pertinent information in the patient's medical record.

• Remember to always be patient-centered and allow patient-driven care planning. Keep benefits patient-focused rather than healthcare team-focused.

• Avoid premature closure on issues. This prevents confirmation bias and deciding on the issue before all the facts have been gathered and examined.

• Be mindful; ask if anything could have been done differently; check whether anything important was missed.

• Promote disclosure and transparency, especially when an error occurs or in case of bad news. Be honest, compassionate and empathetic, tell the truth, and build trust through effective and respectful communication.

Rethinking Ethics

Case managers must rethink ethical self-understanding to fit today's competitive and challenging healthcare environment. Like the traditional physician/patient relationship, the traditional nurse/patient and social worker/patient relationship is transformed once cost containment becomes an issue. Under health insurance plans, nurses — and case managers in particular — may have conflicting loyalties. They have obligations both to their patients and to the payer organization for which they work. Balancing these obligations in an ethically appropriate way requires no longer thinking in terms of maximizing the interests of their patients. Recognizing this important point is the first step in reformulating the traditional ideal of the case manager and social worker as patient advocate.

Often, case managers advocate for the patients they serve and execute care plans to safeguard what is in the best interest of patients. However, case managers also must work with representatives of the health insurance plans and payers to ensure effective use of healthcare resources and adherence to the insurer's utilization management procedures, such as provision of a treatment after it has been authorized by the health insurance plan. In such situations, waiting for authorization may result in delaying treatment, which may ultimately cause suboptimal outcomes. The case manager in these situations struggles between safeguarding the patient while meeting the expectations of the health plan.

Summary

This month, we discussed the basic tenets of ethics as they apply to case management professionals in today's world of managed care, value-based purchasing, and cost containment. We will conclude next time with some real-world examples and ethical standards that apply to all case management professionals. ■