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INSIDE

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Don't let patients suffer — explore range of end-of-life services

Survey shows Americans not getting the care they need

When **Catherine Mullahy's** father died of Alzheimer's disease three years ago, she learned firsthand the frustration faced by families across America when she encountered resistance among health providers as she dealt with myriad end-of-life issues.

"If I — as an experienced, professionally assertive case manager, and staunch advocate for my Dad — was met with such problems, I couldn't help but question what was happening with other patients, their families, and the case managers who advocate for them," says Mullahy, RN, BS, CRRN, CCM, immediate past president of the Case Management Society of America (CMSA) and president of Options Unlimited, a Huntingdon, NY, case management company.

Her personal experience and those of her case management clients planted the seeds for the Little Rock, AR-based CMSA's recent survey on end-of-life (EOL) issues.

"Despite the end-of-life resources available, I was seeing far too few patients actually able to utilize them to the fullest extent," Mullahy says.

The CMSA survey points up the problems that case managers who deal with terminally ill patients and their families confront and concluded that our nation's medical system may be failing citizens at the end of life.

Of the 197 respondents to the CMSA survey, 105 wrote personal responses to an opportunity to share their EOL stories.

"This overwhelming outpouring alone confirmed for me and CMSA that case managers are passionate advocates for their patients throughout their lives," Mullahy says.

The results of the survey and a white paper detailing how case managers can help in EOL situations are expected to be available later this month.

Respondents in the four-week Internet survey reported that 75% of their patients receive 30 days or less of the six months of hospice care

available to the terminally ill and that more than half of them spend 14 days or less in a hospice situation.

As a result, the case managers report, people are dying without the help of adequate pain management, grief counseling, legal and financial consultations, and support groups that should be available to guide them and their families through difficult times.

"Not only are late referrals to hospice care still a problem, it's worse than it was 10 years ago. It is the fault of the health care professionals who are not doing a good job of educating people about hospice care," says **Michael J. Demoratz**, LSCW, CCM, PhD, president of CareMedical Systems Inc., and a case manager who often deals with the terminally ill.

Demoratz reports that many of his patients die within a week of being referred to him for EOL assistance.

"It's beyond frustration," he says. "It's just putting out fires."

EOL services

The CMSA survey's findings are backed up by a 1999 survey by the National Hospice Foundation that showed that less than 10% of Americans know that hospice care is fully covered by Medicare, and nearly a third did not know whom they would contact about getting the best care during life's last stages.

"Despite the fact that hospice care has been successful in America for more than two decades, one-third of Americans do not know that only hospice offers what people say they want at the end of life: choice in care, control of pain, medical attention, help for the family, spiritual and emotional support, and the option to remain in their own homes," says **Stuart Lazarus**, chairman of the board of the National Hospice Foundation.

One of the biggest reasons people don't get the EOL services they should is that few people, including case managers, know what those services are, asserts **B.K. Kizziar**, RNC, CCM, CLP, owner of B.K. & Associates, a Southlake, TX, case management consulting firm.

"The services change almost by the day, and we have to be very vigilant to update ourselves on community resources and covered benefits through health care payers and other sources," Kizziar says.

"One of the biggest challenges I have faced as a case manager is lack of communication regarding expected outcomes from the physician to their patients. They may order hospice care but not explain to the patient/family that the disease is at the terminal point," one respondent to the CMSA Internet study wrote.

Others spoke of their frustration that physicians don't talk with the patient and families about their advance directives before they get too sick to speak for themselves.

But even when EOL issues have been handled, families and case managers may face problems persuading the medical team to carry out the dying person's last wishes.

Mullahy's personal experiences mirror some of the difficulties that families of terminally ill people face.

"When my father was still mentally competent, we met with an elder-care attorney to discuss all related EOL concerns. The appropriate documents were prepared, executed, and notarized. Although copies of these documents were presented to my father's health care team, his wishes were ignored and routinely — sometimes rudely — challenged," she recalls.

Because they are the only health care professionals who work with patients over multiple treatment settings, case managers have an opportunity to have an impact on the patient's final days.

"Case managers are as vital to insuring a good outcome during a patient's final illness as at any other life stage. The challenge case managers face when it comes to EOL issues is to help health care professionals, patients, and families recognize that a peaceful, dignified death is a good outcome when all other options are exhausted," says **Jeanne Boling**, MSN, CRRN, CDMS, CCM, CMSA executive director.

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- Disease management for less-common diseases
- How you can prove the value of case management

Just as case managers would routinely inquire about previous medical conditions, current medications and the patient's understanding of the treatment plan, they should ask about EOL, Mullahy says.

Here are some suggestions for case managers on helping patients and their families in EOL situations:

- **Get involved** during the admissions process when issues such as advanced directives and health care proxies are being discussed.
- **Make sure** your patients all have advanced directives and other EOL documents, especially in situations where death is highly likely.
- **Ensure** that members of the treatment team know and respect the wishes of your clients.
- **Examine** your own feelings about death, and confront your own ideas and fears.
- **Consider** if you need more education, current information, or even counseling in order to be able to advocate for your patients.
- **Help** family members of your terminally ill patients tune into every resource they can draw on for support.
- **Find out** what community support (such as strong religious ties) the family has and help them enlist help. ■

Community resources can supplement EOL benefits

Research will help you identify what is available

When a patient has a terminal illness, it's often possible to complement the patient's health care benefits with community resources to make his or her final days more comfortable and less stressful for the family, asserts **B.K. Kizziar**, RNC, CCM, CLP, owner of B.K. & Associates, a Southlake, TX, case management consulting firm.

"One of the biggest gaps is not coordinating what the payer provides with resources that are available in the community," she adds.

For instance, the American Cancer Society will help meet simple durable medical equipment needs and provide support groups for families and patients. Some community organizations provide pastoral services for families to guide them through the difficult days.

"Sometimes, we as case managers are so busy looking at what is covered by insurance that we fail to look at what is available in the community," Kizziar says.

You don't have to know everything about every service available, she adds, but know where to find out if any services your patients need are available in your community.

One of the best ways to update yourself about community and other resources is through the Internet, Kizziar says. **(For a list of Internet sources, see p. 100.)**

"I was recently exploring resources for traumatic brain injuries, and even though it's my specialty, I found out services I didn't know were available," she says. Benefits for hospice services differ widely among payers, but typically, there are elements of the hospice benefit that people don't take advantage of, she says. "We're not always good about assessing the full extent of what is available through the hospice benefit."

Among the often-untapped hospice benefits are social services, which include social worker benefits and support groups for the family. The best place to start looking for community services is under "Hospice."

Then check out disease-specific organizations, such as the American Cancer Society. Some of these organizations have very specific resources for the specific disease, Kizziar says.

Working as a team

More difficulties are likely to arise as the family or individual decides where the patient will spend his or her last days.

"It's difficult when you have a dying patient and their situation does not meet a payer's standard to be an inpatient at a hospital or a nursing home but the family is ill-equipped by experience or desire to handle the patient at home. It's a real dilemma for case managers," Kizziar says.

She advises case managers on the payer side to work with the hospital-based case manager to find out what resources are available in the community and if it is necessary for the family to go home to find ways to support the family as much as they can.

"It is important for payer and provider case managers to work together as a team. There is never a reason to work at cross-purposes, but they shouldn't even consider it in this situation," Kizziar says.

One of the biggest challenges the case manager faces is trying to help with end-of-life issues

End-of-life resources on the Internet

Here are some resources for end-of-life information available on the Internet:

- American Cancer Society: **www.cancer.org**
- American Parkinson's Disease Association: **www.pda.healthology.com**
- Association for Death Education and Counseling: **www.adec.org**
- Colorado HealthSite, a nonprofit organization providing health care information: **www.coloradohealthsite.org**
- American Hospice Society: **www.hospiceinfo.org**
- Healthlink USA, an Internet search provider: **www.healthlinkusa.com**
- American Academy of Hospice and Palliative Medicine: **www.aahpm.org**
- Robert Wood Johnson Foundation: **www.rwjf.org**
- Last Acts, a national coalition to improve end-of-life care: **www.lastacts.org**
- American Association of Retired Persons: **www.aarp.com**
- American Counseling Association: **www.counseling.org**
- American Society of Psychosocial & Behavioral Oncology/AIDS: **www.ipos-aspboa.org** ■

when the patient and family are in denial, she adds.

"There are times when physicians fail to tell patients they are terminal. It's very tragic," Kizziar says.

At these times, the case manager may be the person who has to break the news to the family.

You need buy-in from the entire treatment team, including the physician, to bring the patient and family to the point that they accept the diagnosis. This is when you need to marshal your forces to help the family through the transition period.

"We have to make sure we are all on the same page and in agreement that that is what is going to happen. You should advise the physician you are doing it, even though it is the patient's and family's right to know," Kizziar says.

Sometimes the family wants to keep the news from the patient. That's why everybody on the treatment team needs to be on the same game plan to help the family identify resources available for them.

The physician may have his or her own objectives in not telling the family. He or she may want to wait until after a few more tests.

"If he has a reason not to tell the family the patient is terminally ill and you tell them, it can cause more problems and turmoil, rather than being supportive to the family," she says.

When it's a child who is terminally ill, the situation is even more difficult because the parents may feel guilt that they did something wrong.

"With a terminally ill child, it's vitally important for the case manager to be up front and objective and to apply every resource available," Kizziar says. ■

Malpractice issues likely to plague CMs in the future

Follow job descriptions, rules to avoid liability

Case managers are being identified as defendants in medical malpractice and negligence lawsuits, and their exposure is likely to increase in the future, says **Cathy Nearhoof**, RN, BSN, CCM, NMCC, CLNC.

Nearhoof, owner/consultant of Pittsburgh-based Integrist Healthcare Consulting, works with both plaintiff and defense attorneys and insurance companies by assessing, researching, and preparing medical malpractice, personal injury, workers' compensation, and criminal cases for litigation.

It takes so long for legal issues to work their way through the system that lawyers currently are dealing with issues that arose in the mid-to-late 1990s, Nearhoof says.

"Prior to then, there was little documentation in the medical records with case managers. Now, there is an increased inclusion of case managers within the health care system, and attorneys are not always knowledgeable about the role of a case manager. Needless to say, plaintiff attorneys are delighted to identify an additional defendant or someone who can be deposed and/or potentially increase the strength of their case," she adds.

A case manager's inclusion in a malpractice case is based on a review of the medical records, assessment of the case manager's expected role, and whether the case manager breached his or her duty based on established case management

standards of care.

"The answer to the possibility of a breach of duty is found in the job and program description." Nearhoof says. "The question becomes: Did that case manager do what the hospital or the employer said they would do?"

She suggests that case managers minimize their exposure to liability by adhering to case management standards of care, following the expectations outlined in their job description, and treating their patients professionally and with kindness and consideration. **(For more tips on avoiding liability, see related article, below right.)**

Understaffing a problem

When a case is being considered for a lawsuit, there will be an assessment of all health care professionals who provided patient care or coordination to determine if the patient was thoroughly assessed, if his or her problems were identified, and if an appropriate plan of care was implemented, Nearhoof says.

When she assesses a case, she researches the medical records to determine if the health care professional assessed the patient thoroughly, identified the problem, and if there were appropriate interventions in accordance with established standards of care.

For instance, she looks for documentation that the case manager made sure the specialist saw the patient before the weekend and if he or she followed up on the plan of care.

"In health care today, understaffing by nurses is reaching critical proportions. It's not uncommon to see a case manager do the assessment, put something in the care plan, and not show up until discharge. But there are so many opportunities that exist for the case manager to intervene and positively impact the care," she says.

It all boils down to duty, and no matter what your health care role is, whether you're a nurse, a social worker, or a case manager, your duty is always to the patient, Nearhoof says.

"When I see a case manager who seems to be focused only on utilization management, it sends up a red flag. Optimization of resources doesn't always coincide with what is best for the patient," she says.

Finding the balance

Being a case manager today is often a matter of finding a balance of what is best for the patient with what is best for the entity that pays the case manager's salary, Nearhoof says.

Finding the balance is a real challenge for case managers.

"There is ongoing confusion in health care as to whether a case manager is truly a case manager [but] a utilization manager with a change in title," she says.

Case managers, particularly those in workers' compensation cases, may be conflicted about who their duty is to, Nearhoof notes.

For instance, if an insurance case manager handles a head injury case with a goal of returning the patient to his previous employment, it is important for the case manager to maintain objectivity, assessing all aspects of the injury, the potential for recovery, and establishing an appropriate plan of care with realistic return-to-work goals, she adds.

"Sometimes, insurance case managers feel that they must get the patient back to work no matter what. Getting a patient back to work is part of the job, but it can't be knowingly accomplished at the risk of further injury or incomplete recovery," Nearhoof says.

A case manager's duty is to assure optimal outcomes for the patient and not the insurance company, she adds.

"Sometimes it means the employer isn't going to get somebody back to work. It becomes confusing when the insurance company and/or the employer are pressuring you to inappropriately expedite the patient's recovery and return to work. It is the job of the case manager to first ensure that each patient or client receives the treatment they need," she adds. ■

To avoid lawsuits, be the best CM you can be

Learn, and follow professional standards of care

The best way to avoid being named in a malpractice lawsuit is "to be the most knowledgeable and professional case manager you can. Period. End of story," **Cathy Nearhoof**, RN, BSN, CCM, NMCC, CLNC asserts.

That means familiarizing yourself with the case management standards of care and following them to the letter, says Nearhoof, owner/consultant of Integrist Healthcare Consulting in Pittsburgh.

Many case managers don't know that there are published professional standards of care, she says. "How can you travel from one place to another when you don't have a map?"

Keep up with CE

Work and study to improve yourself professionally, Nearhoof suggests. Keep up with your continuing education units, even if it means doing it on your own time and expense. Read professional journals, join professional organizations, and get certified.

Certification doesn't necessarily make you a better case manager, but it does announce your commitment and dedication to the profession of case management, she adds.

"As a profession, we must take the responsibility and assume accountability for our professional outcomes and development if we are going to be taken seriously," she says.

Here are some other suggestions from Nearhoof that may help you avoid a lawsuit:

- **Show sincere concern for your patients' well-being.**
- **Include the patient in conversations with the practitioner and family members.**
- **Don't make promises you can't keep.**

For example, don't promise you will send a patient to a certain facility when she gets out of the hospital. She may have to go to one she didn't choose and may look at you to blame.

- **Document everything.**

Make a note if the patient is continuously noncompliant. If the patient has been advised to use the call bell, and you find him out of bed without having called for assistance, document it. If a patient is told she needs to go to physician therapy three times a week and she only goes occasionally, it's important to document her noncompliance.

- **Treat all patients the same — with professionalism, kindness, and sincerity, whether they are compliant or not.**

"I've heard of patients who were truly injured as a result of physician or nurse negligence but who refused to sue because the clinician was kind to them. That is sometimes the tiny thread that prevents a lawsuit, " Nearhoof.

- **Treat everybody how you want to be treated no matter what, she advises.**

For instance, just because you think a patient is malingering, that doesn't mean you should become condescending or act inappropriately. ■

DM should include psych component for best results

Depression can affect outcomes in ill patients

If your disease management treatment doesn't take psychological factors into consideration, your results could be less than optimal.

"If a patient has undiagnosed depression, a case manager can be fighting an uphill battle when trying to get the best response possible for a treatment plan," says **Sam D. Toney**, MD, founder of CMS Healthcare Integrated Inc. in Tampa, FL.

That's why CMS Healthcare Integrated has developed an integrated care program that combines case management and disease management of both medical and behavioral conditions.

"If a disease management program is treating only the disease and not the entire person, you lost the opportunity for an increased impact," Toney says.

CMS Healthcare provides comprehensive and integrative medical and behavioral health utilization management, case management, and disease management for health plans, physician organizations, government entities, large self-insured employers, and other clients.

The company offers a turnkey program on an outsource basis, or it will train companies to conduct the program internally.

"We can share the responsibility if the company wants to provide the services during the day and have our staff provide the telephone support after hours," adds **Cheri Lattimer**, RN, vice president, medical management.

One point of contact

The program is unique in that it combines the mental and medical case management aspects into one comprehensive disease management program.

"We believe that having one point of contact is best for the patient. It's more user-friendly than if they had to deal with several different nurse care managers. We are trying to integrate the process," Lattimer says.

For instance, congestive heart failure may be a priority of treatment when the patient is first diagnosed, but as the disease progresses and takes a toll on quality of life and interpersonal

relationships, depression can become the primary disease that needs to be treated, Toney says.

"Our experience has been that these comorbidities and how they are related are dependent on what is primary in the member's life at that time," Toney says.

When patients are more severely depressed, they may be seeing a psychiatrist who focuses on the depression but doesn't coordinate with the medical side. That's why a coordinated approach is essential, he adds.

Program has member education

There are more than 120 million Americans with chronic conditions such as diabetes, asthma, heart disease, and arthritis.

This population is responsible for 75% of all medical spending. Their medical costs are 16 times greater than people without chronic conditions. They are 10 times more likely to be hospitalized, Lattimer says.

They are likely to see eight or more providers in a year, Toney adds.

More than 19 million people have clinical depression at a cost of $30.4 billion a year in medication, benefits, and lost working days.

When a patient has a chronic disease and suffers from depression, the cost of the illness is likely to soar, and the chance for good outcomes becomes less likely.

"A depressive illness with significant symptoms could interfere with the treatment plan on the medical side," Toney says.

For instance, with diabetics, depression can affect the appetite and eating habits in either direction. Depression often causes craving for carbohydrates, which can affect the glucose balance.

Depression causes decreased levels of concentration, decreased energy levels, and can have a physiological effect on the immune system.

"It's not just the mere fact of being able to remember how to take one's insulin. It's the whole physiological balance. Depression can really wreak havoc on a treatment plan," Toney adds.

CMS Healthcare Integrated's goal is to coordinate programs that will serve the chronically ill people at risk for adverse outcomes and expensive care. They identify the medical, functional, social, and emotional needs that increase the risk of adverse health events, address the disease comorbidities, and integrate care that often is fragmented by setting, condition, or provider.

"We want to integrate disease management for the chronically ill and case management targeted at high-risk patients," Lattimer says.

Case managers with both behavioral and medical case management experience staff the program.

Program components include member education to teach patients about the overall management of depression and their chronic disease, and to help them manage the disease and improve their quality of life. **(For details on how the program works, see related article, below.)**

The program is new, but early data show a reduction in costs and improvement in quality of life for the patient. For example, a congestive heart failure patient with clinical depression was diagnosed with diabetes and facing a limb amputation.

"He didn't feel like there was any point in going forward," Lattimer recalls.

Because of the depression, the patient had been missing office visits and was refilling but not taking his medication.

"The depression was keeping him from being motivated to follow through with what he was supposed to do," she adds.

The case manager worked closely with the patient, encouraged him to actively participate in his care and helped him organize his daily life. She worked with the various providers to coordinate the care he was receiving.

As a result, the patient began seeing his physicians more regularly and reported an improvement in quality of life. ■

System coordinates mental, physical sides of illness

Interventions depend on severity of both illnesses

When they manage the care for patients with clinical depression along with a chronic disease, case managers at CMS Healthcare Integrated coordinate care between physicians who are treating the medical condition and those treating the behavioral condition.

"We want to balance the scales in both directions and act as a conduit between the behavioral side and the medical side," says **Sam Toney**, MD, a board-certified psychiatrist and founder of the Tampa, FL-based company.

Patients are identified for the program through

claims analysis, including ICD-9 codes, DMS-4 codes, and pharmacy claims.

The process tags patients with a chronic disease who are not diagnosed with depression but are being treated with an antidepressant.

Case managers who have behavioral health experience as well as medical management expertise conduct a comprehensive clinical assessment that includes past history, current medication, psychosocial support, and other medical and psychological factors.

The CMS software program guides the case managers as they do the assessment. Once the assessment is completed, patients are stratified into four levels based on the severity of their medical and behavioral problems.

Based on patient answers, the system recommends a frequency of contacts, goals, and milestones but allows the case manager to adjust them depending on his or her clinical judgment.

The level assigned dictates the strategy for managing the care. For instance, if a patient with diabetes has a comorbidity of depression, the stratification takes into account the severity of the depression as well as the diabetes.

"This guides us in terms of care strategy with case management and disease management. It's the key to where the two interventions link up," Toney says.

Patients with Level 1 or Level 2 depression probably can be effectively treated by the primary care physician and not require psychotherapy.

CMs can empower physicians

The case managers work closely with the primary care physician and assist him or her in making the diagnosis of depression and following the treatment algorithms.

"The case manager can empower the primary care physician to use his or her skills and to write prescriptions that can help the patient get better," Toney explains.

Patients at Level 3 or Level 4 were probably already diagnosed as depressed.

"This may be where the primary care physician is struggling. We may recommend a transition to a specialist to determine whether or not psychotherapy should be part of the treatment plan," Toney says.

The care managers work with the family to help them understand the impact that being depressed can have on medical compliance.

They work with the various providers the patient is seeing, helping coordinate the care to deal with the whole person and the whole illness, including both the mental and physical health components. A key aim of the program is to promote a good relationship among treating providers, alerting them to what is happening with patients as they see various providers.

Physicians receive a monthly summary of patient activity as well as ongoing alerts of any problems the patient may have. Patients receive a newsletter, resource guide, and daily activity planner.

CMs monitor medication

Educational materials are geared to the individual and may include an overview of the disease; symptom recognition; medication information; how diet, exercise and other lifestyle issues can affect outcomes; and information on lifestyle issues such as weight reduction, smoking cessation, and relaxation; and how to manage special situations such as holidays and vacations.

The care managers design a specific care plan for each member, taking into account the patient's history, problems with medication compliance, and other factors.

Members are monitored throughout their course of management to find out how well they are doing and how they are responding to treatment.

The case managers call the patients at regular intervals, at the patients' convenience. Since the call center is open 24 hours a day, seven days a week, the case managers may call the patients in the evening or on weekends if that is the most convenient time.

Using proprietary computer software, the case managers monitor prescribed medication to make sure one doesn't adversely affect the other and that patients are not taking psychotropic medication that may have an impact on their disease.

The program is designed to identify when a patient who is being managed for a chronic disease experiences depression. For instance, a member might tell the case manager, "I didn't feel like eating today." That is a key for the case manager to conduct a five-question disease management depression assessment.

The Minnesota Quality of Life survey and the SF 36 Health Survey are among the outcomes measures used to track patient progress.

The company has a secure web site and operates a 24-hour-a-day call center at its Tampa headquarters. It is planning to open two additional call centers within the next 18 months. ■

Personal visits give insight into return-to-work cases

CMs should see the home, workplace firsthand

When you're managing return-to-work cases, there's no substitute for personal visits to the home and job site, asserts **Diane Schneider**, CDMS, CCM, CRC.

"During a home visit or site visit, the case managers can observe many situations that could impact recovery. You see firsthand the social factors, family issues, and working conditions that are unique for each ill or injured person," says Schneider, who is director of disability management case management products for Intracorp, a Philadelphia-based health care management company.

The company provides case management services for a variety of clients including insurers, employers, third-party administrators, unions, state and local governments, and managed care organizations. Intracorp provides both telephonic and on-site case management services to people who are ill or injured.

"On those cases that need a deeper level of intervention, Intracorp's standard protocol is to have an experienced case manager meet face-to-face with the injured or ill person, employer, and providers," Schneider says.

The interview, which typically takes an hour to an hour and a half, gives the case manager a total picture of the person, his or her family, and the environment in which they live.

"These face-to-face visits add incredible knowledge and insight that help the case manager coordinate medical services and return-to-work job opportunities as quickly as possible," she adds.

The case managers determine the ill or injured person's understanding of their diagnosis and treatment, talk to them about their employer, obtain feedback about their perceived ability to work in any capacity, and help them work with the insurance company, their employer, and their providers.

"All the time, we are interviewing the ill or injured person, we are observing their interactions with family members and friends and documenting the home environment," Schneider says.

Home visits help the case managers determine all of the factors that may affect recovery and return to work.

For instance, there may be family members who cater to ill or injured relatives and won't allow them to do the activities of daily living that can help recovery, or the injured client may be doing home activities that actually exacerbate his or her symptoms and lengthen the recovery time.

"When I did home visits, I encountered a lot of people with back and knee injuries who were now involved in their family's childcare and demonstrated improper body mechanics or participated in hobbies that required physical capabilities that were beyond safe levels given their current diagnosis and stage of recovery," she says.

Case managers are able to spot leisure activities or hobbies that the injured worker should avoid during recovery, or may discover a hobby the client has given up that can be beneficial to recovery.

Site visits

A case manager may detect indications of financial difficulties, drug abuse, or other factors and arrange for help from community agencies as well as alert their providers of factors at home that may be affecting their current treatment plan and recovery.

"These site visits give case managers information we can share with the provider that assists them in understanding the full picture and help them build a treatment plan that meets the individual's needs," Schneider says.

For instance, a case manager may notice that a patient is having problems with daily living skills or is not doing them appropriately and can suggest to the provider that home visits from a physical therapist may be beneficial.

Onsite visits to the work environment also are incredibly beneficial, she says.

"It is rare when an employee's description of their job matches an employer's description. Yet as a case manager, it is your role to determine if the job matches the physical capabilities outlined by the provider to assure a safe return-to-work environment," Schneider says.

Visiting the job site takes the guesswork out of determining the job requirement and helps ensure a safe and sustained return to work, she says.

It gives the case manager the opportunity to complete a detailed analysis of the job and define the physical requirements needed to perform that

job, allowing the case manager to provide the physician with detailed information needed to assess when the employee can return to work safely.

"While visiting the job site, we also educate the employer by identifying simple modifications and other temporary tasks that can be performed with less physical requirements to assist with a transitional return-to-work during recovery," she adds. ■

Negotiate with everyone, but aid the injured worker

Industrial CM means a safe return to work

Case managers who work with injured or ill workers may find themselves collecting and providing information for the employee, providers, employers, attorneys and union representatives, but their main purpose is to make sure the employee can return to work safely.

"We truly are an advocate for the ill or injured employee. Our role is to do the right thing even if it doesn't please everybody along the way," says **Diane Schneider**, CDMS, CCM, CRC, director of disability management for Intracorp, a health care management company based in Philadelphia.

Intracorp has more than 1,100 case managers all over the country who are medical, return-to-work, and community experts and liaisons in their particular area. The injuries they handle range from insignificant to catastrophic.

The case managers coordinate medical services for ill or injured employees, assist employees in understanding their abilities and disabilities, educate providers on patients' home and work life, and work with employers to identify opportunities for employees to return to work safely.

"Case managers play a critical role during an employee's recovery from an illness or injury. They are the key contact for the employee, provider, and employer in the coordination of quality medical services, and a safe and sustained return to productivity," she adds.

Making sure the employee returns to a safe work environment is the case manager's main concern, Schneider says.

"Some employers are incredibly sophisticated with return-to-work opportunities, and they have built a program from the employees before the injuries happened. With other employers, the injured workers don't come back to work until they are fully recovered," she says.

If the employer is able to accommodate the employee with modified duty work, everyone benefits, the case managers tell the employers.

"If someone is sitting at home recovering, they may become depressed, and the psychological ramifications can last a long time. We want to keep them busy and productive and be safe about it," Schneider says. ■

Public awareness about case management needed

New CMSA leader discusses projects

Case managers are one of the best-kept secrets in health care and should work to educate consumers and physicians about the vital role they play in patient care, says **Karen Chambers Knight**, RN, CCM, CDMS.

Clearly defining the role of case managers and letting the public know what they do is one of Knight's pet projects as she takes the helm of the Case Management Society of America (CMSA).

Knight is associate director of the Medicaid maternity program for VIVA Health in Birmingham, AL.

"There seems to be a lack of clarity of the case manager role. We see a lot of blending of roles — case management, utilization management, and disease management. Many physicians understand what we do, but there are still many who don't," Knight says.

For the second year, CMSA invited representatives from across the health care spectrum to participate in an industry council.

"We got their opinion on where they see the industry going. It is our way of keeping in touch with the different areas. Case management covers such a broad spectrum," Knight says.

Standards of practice

One of the key issues in that meeting, at the chapter presidents' meeting, and the special-interest group meetings was educating the public on what case managers do.

One potential vehicle for educating the public about case management is the organization's Standards of Practice, first published in 1995, which recently have been revised. The final version of the revised standards should be completed this fall, Knight reports.

"The Standards of Practice truly represent what standards case managers should be following. A lot has changed in the health care industry in seven years. The way it's practiced, the way it's administered, and the settings have changed. We felt it was time to take a good look at them and bring them up to date," she says.

The organization has hired public relations consultants Lauren Hoffman and Deborah Jensen of Atlanta-based Healthcare Writing, Editing, and Research Services, to educate the public about the role of case managers in health care today. The project is being funded by a grant from a CMSA member.

Outcomes on the agenda

Outcomes in case management and providing more education for members are Knight's other pet projects in the coming year.

"My philosophy was to pick three key areas and focus on them. If we accomplish them before the year's up, we can find more things to do," Knight says.

Establishing outcomes to measure the effectiveness of case managers has been a big issue for several years, Knight says.

"One reason people don't understand case management is that our jobs are so complex and what we do varies from case to case. It's been difficult for people who haven't been involved to understand the impact that case management can have," she adds.

CMSA's Council for Case Management Accountability has been working on development of an expert panel to determine what outcomes measures case managers can use to show value, Knight says. The council will publish additional "state-of-the-science" papers on the topic.

Good outcomes means not just cost-effective care but improved quality of life, she adds.

Knight wants to expand CMSA's mission to provide educational opportunities in multiple forms to meet the members' needs. "The needs of our members are so complex. Some can travel and some can't. We want to provide education opportunities for all of them," she says.

Despite national trends showing a decline in conference attendance, CMSA's 12th annual conference in Orlando in June had the highest attendance ever.

Members who could not attend the conference, may obtain continuing education units (CEUs) on-line from CMSA's WebEd.

Some sessions at the annual conference are available on-line, with the option of taking an on-line test and printing a CEU certificate.

"It's a great way to get CEUs. If you buy the tapes, you can't see the graphics. With this system, you can see and hear the entire presentation just like you were at the conference," Knight says.

This year, for the first time, CMSA gave

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Editorial Questions

Questions or comments? Call **Mary Booth Thomas** at (770) 934-1440.

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CE questions

9. According to a 1999 survey conducted by the National Hospice Foundation, what percentage of Americans knows that hospice care is fully covered by Medicare?
A. 50%
B. 32%
C. 17%
D. fewer than 10%

10. A disease management care program developed by CMS Healthcare Integrated Inc. in Tampa, FL, identifies eligible patients using which of the following?
A. ICD-9 codes
B. DMS-4 codes
C. pharmacy claims
D. all of the above

11. The Minnesota Quality of Life survey is among the outcomes measures used to track the progress of patients in the disease management program developed by CMS Healthcare Integrated Inc.
A. true
B. false

12. The Case Management Society of America's Standards of Practice was first published in what year?
A. 1993
B. 1994
C. 1995
D. 1996

Answers: 9. D; 10. D; 11. A; 12. C

attendees at the conference a CD-ROM with conference materials instead of a manual filled with paper. The response was positive, Knight says.

In her speech at the CMSA conference, Knight challenged members to become involved in their organizations over the coming year.

"There is something each of us can do. I challenged each case manager to do whatever they can do to make the profession better. It will take all of us working together to accomplish this," she says. ■

CE objectives

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

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

Reports From the Field™

Drug cost a barrier to prescription compliance

Adults with disabilities do not take their medicine as prescribed because they cannot afford to, and more than half report resulting health problems, a national study has shown.[1]

Medication affordability is a real problem for people with chronic illnesses or disabilities, regardless of age, the researchers conclude.

"About 63% of the respondents did not receive Medicare and would not be helped by any of the competing congressional proposals to create a prescription drug benefit," says **Jae Kennedy**, PhD, assistant professor of Health Policy and Administration at Washington State University in Spokane, and principal investigator.

The researchers used data from the 1994 and 1995 National Health Interview Surveys to estimate national rates of prescription noncompliance and resulting health problems.

The problem may be even more severe since the surveys used in the analysis are somewhat dated, Kennedy adds.

"Drug costs have skyrocketed in this period since the data were collected, potentially threatening the health and economic security of many more people with and without disabilities," he says.

Reference

1. Kennedy J, Erb C. Prescription noncompliance due to cost among adults with disabilities in the United States. *Am J Pub Health* 2002; 92(7):1,120-1,124. ▼

Infant mortality rate dropping, report says

U.S. children are less likely to die in infancy, less likely to smoke in the eighth or 10th grade, and less likely to give birth during adolescence than they were a few years ago, according to the sixth annual report, "America's Children: Key National Indicators of Well-Being, 2002."

Infant mortality rate dropped from 7.2 deaths per 1,000 live births in 1997 and 1998 to seven deaths per 1,000 live births in 1999, the study says.

"The drop in infant mortality is very encouraging. Infant mortality is a stubborn, resistant problem; so even a slight decline is a victory," says **Duane Alexander**, MD, director of the National Institute of Child Health and Human Development.

The figure indicates that the U.S. Department of Health and Human Services' Healthy People 2000 goals for reducing infant mortality were met a year early. Here are some other highlights of the report:

- The adolescent birth rate in 2000 was 27 per 1,000 women ages 15-17, a drop from 29 per thousand in 1999.
- The percentage of children having at least one parent working full time increased from 79% in 1999 to 80% in 2000.
- The majority of children — 82% — are in very good or excellent health.
- Although children living in poverty are less likely than children in high-income families to be in good or excellent health, the gap is narrowing. In the most recent study, 70% of low-income children were in very good or excellent health compared with 60% in 1984.

• In 2000, 64% of all U.S. children were white, non-Hispanic; 16% were Hispanic; 15% were black, non-Hispanic; 4% were Asian / Pacific Islander; and 1% were American Indian / Alaskan Native.

The report is available at http: / / childstats. gov. ▼

Drug formularies increase risks for older patients

Drug switching due to drug plan formulary restrictions can have a negative impact on the health of older Americans, according to a survey by Project Patient Care, a nonprofit organization that collects and interprets data to improve patient care.

The survey found that last year alone, 12% of all adults ages 50 and older were prescribed or switched to a less expensive drug due to formulary restrictions.

About 13% of those surveyed report that the new drug was ineffective in treating their condition, and 22% of patients say they experienced side effects from the new medication. More than half reported making extra phone calls or visits to their health care provider or the pharmacy.

"It's always easy to talk about the financial impact that drug switching has on patients, but the health impact has been largely overlooks until now. As provider and policy-makers construct ways to improve the health care system, they should consider the health impact over and above the economic costs. And above all, the decision about what medication is best should be left to the health care provider and the patient," says **David Chess**, MD, founder, chairman, and president of Project Patient Care.

More details on the study are available at www. projectpatientcare.org. ▼

AHA releases disaster readiness advisory

The Chicago-based American Hospital Association (AHA) has issued a disaster readiness advisory. As part of this process, AHA has sent out the Centers for Disease Control and Prevention's (CDC) recommendations for a national smallpox vaccination strategy, along with a checklist of AHA-recommended next steps for hospitals.

In the advisory, which was faxed to members on July 8, the AHA recommends sharing all pertinent information with the hospital disaster readiness team, reviewing the bioterrorism plan in the event of a smallpox outbreak, finding out which hospitals are the referral centers in the case of an outbreak, and connecting with community public health leaders to integrate emergency response plans.

To access the advisory, go to the AHA web site, www.aha.org, and search under "Disaster Readiness." ▼

Nursing shortage reaching crisis level, says MHA

More than 60% of Massachusetts hospitals rate the shortage of nurses in certain departments as "moderate or severe," a new survey reports. The research, conducted by the Massachusetts Hospital Association (MHA) and the Massachusetts Organization of Nurse Executives, also showed the overall vacancy rate for RNs was 9.9%. The vacancy rate for certified nurse assistants was 13.6% in acute-care hospitals and 8.2% in specialty hospitals.

According to the survey, overall nurse vacancy rates in Massachusetts have climbed steadily since 1996, but current nursing vacancy rates are the highest in nearly 14 years. In a press release, the MHA said, "The shortage of front-line caregivers in our hospitals is reaching crisis proportions. The vacancy rate drives home the need for all health care stakeholders to redouble our collaborative efforts to replenish the nursing work force." ■

Send us Resource Bank items

If you have a new resource, conference, or seminar that can help other case managers do their jobs better or more efficiently, *Case Management Advisor* wants to hear from you.

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