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Case Management ADVISOR™

Covering Case Management Across The Entire Care Continuum

INSIDE

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Telephonic case managers produce long-distance results

Good communication and listening skills pay off

A diabetic who lived in Michigan had severe gastrointestinal problems, was making frequent visits to physicians, and constantly was in and out of the hospital when a California-based case manager at Beech Street Corp. was assigned to his case.

The first 90 days he was in case management, the man spent 80 days in the hospital, recalls **Teri Howard**, RN, manager of health care management for Beech Street.

The case manager looked into the situation and discovered that the man was homeless and had no one to cook his meals. He was hungry after discharge and would go to a fast-food restaurant for a meal. A few hours later, he was back in the emergency department with stomach problems. She found the man a place at the local YMCA and lined up home care nurses to make home visits to coordinate his medication. She found a physician to make a home visit to assess his condition and arranged for a local organization to deliver nutritious meals to him.

"Once we got him stable, he was out of the hospital for 40 days out of 90, all because of a coordinated plan of care," Howard adds.

The plan was developed and coordinated by a case manager who wasn't even in the same city as the patient.

The story is one example of how Beech Street's case managers collaborate with community providers through the company's telephonic case management program.

Beech Street, one of the largest independently owned preferred provider organizations (PPO) in the country, operates a network of case managers who handle their patients' care via telephone.

The company, based in Lake Forest, CA, was among the first organizations in the nation to receive accreditation for its case management services from URAC.

"Beech Street strives to provide a multifaceted case management program that focuses on providing personalized care for our clients'

patients," says **Bill Hale**, president and CEO of Beech Street. "Our strong commitment to quality and our flexibility in delivery methods are the keys to our success."

Beech Street contracts with more than 3,300 hospitals, 50,000 specialty care facilities, and more than 345,000 providers. It serves more than 16 million individuals through its network.

Most of the company's case managers are located in Southern California and handle patients from across the country.

Some of the company's case managers are located in several other areas of the country, in some cases at the request of the clients who ask that nurses handling their patients' care be in close proximity.

"We don't have the ability to see the patient in person, but our case managers have developed good listening and communication skills. They have the ability to determine how the patient is doing by the tone of his voice and to pick up verbal cues when there is a problem," says **Nancy Neslen**, RN, senior director for health care management.

The company allows case managers to telecommute and work from their homes.

"Having case managers who telecommute allows us the flexibility to find good nurses who are not just in Southern California. We set criteria that they must meet to be allowed the privilege, but it has worked out well," Neslen says.

The average Beech Street case management nurse has close to eight years' experience in case management.

The nurses are able to access community resources in distant areas via telephone because of their years of experience, Howard says.

"Because we have a large PPO network, we can utilize that as a starting point. The nurses know our contractor vendors and network providers in each area. They may not be able to find the contracted provider they need in a given area, but it does give them a starting point," Neslen adds.

The case managers often e-mail or telephone each other and ask for suggestions and advice on finding resources in certain areas. "Our case managers really do work together even though they are not necessarily sitting next to each other in the office," she adds. If the case managers feel the need for a team conference, they arrange a telephone conference with the attending physician, hospital social worker, hospital discharge planner, or any other team members necessary.

The Beech Street case managers are assigned to particular clients so they can develop a close relationship. Because of confidentially issues, the case managers don't e-mail any confidential information. Beech Street's computerized case management program is a key to the company's success in allowing employees to telecommute.

The company's technology makes it easy for one case manager to pick up and follow another's cases in the event of absences.

"We have minimal hard copy charts. Electronic records are particularly helpful because so many of our employees telecommute and yet can have access to all patient files, so if they're going on vacation, they don't have to move files over to someone else," Howard says. ■

Collaboration key for effective management

CMs work with families, providers, community

Case managers at Beech Street Corp. in Lake Forest, CA, look at far more than the patient's immediate medical problem when coming up with a plan of care. They also examine at psychosocial issues, financial issues, the home environment, and spiritual needs to help identify patients' key problems.

"In case management, the medical diagnosis may not be what is driving the cost. It may be the financial picture or the home environment, says **Teri Howard**, RN, manager of health care management.

Beech Street offers a multifaceted case management program with the goal of achieving cost-effective quality care. The company's case

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management department handles catastrophic illness and injuries as well as long-term illnesses.

"We take a collaborative approach with families, patients, providers, and insurers. We seek assistance from community resources and coordinate care with other agencies," Howard says.

Case managers from Beech Street often get involved with the family from the first day of hospital admission. "We help them understand what is going on, let them know their options for movement through different levels of care, and help them interpret their benefits package," she says.

Patients are referred to case management from a variety of sources. "We have an outstanding utilization review product which goes hand-in-hand with case management. As a result, most of the cases are identified early on, and we can take a proactive approach in helping patients move along the continuum," says **Nancy Neslen**, RN, senior director for health care management.

The company's computer software is set up to flag more than 1,800 diagnoses of catastrophic injuries and serious or chronic illnesses that have the potential for case management.

If the case management flag comes up, when nurses take the pre-certification information, they automatically refer the case electronically to case management.

"The nurses in utilization management also use their judgment to refer cases to case management. For instance, if a patient has repeated admissions in a short period of time, it may be appropriate for case managers to look into the case," Neslen says.

The case managers also have referrals from payers when they have large dollar expenditures that do not necessarily result in hospitalization.

"In this case, they ask us to look at the patient to make sure they are getting the right care in the most cost-effective manner," Howard adds.

Talking with family members

Once a referral comes in, the case managers call the hospital discharge planner and assist in coordinating patient care. They call the family, explain who they are and what they are doing, and get a history of what has been going on with the patient, Howard says.

In a typical case, the case manager makes several phone calls to the family before discharge to gather information about the home environment, comorbidities and any other potential problems, and find out what is needed to keep the patient safe in that environment.

Once the case manager identifies the patient's problems and needs, he or she works together with the physician, the family, and other providers to come up with a plan of action.

"The case managers make sure that the patient is in an appropriate level or care and is receiving the best possible care in the lowest-cost setting. They coordinate any additional needs, such as durable medical equipment or home health. We often request flexing of benefits if it will get the patient to a more appropriate level of care," Howard says.

Case managers also consult with Beech Street medical consultants and hospital discharge planners to identify potential needs up front.

"We identify the contracted providers in that area right up front and get referrals going so that at the time the patient is discharged, the bed is in place and home health is set to come out the day of discharge," Neslen says.

Chronic disease patient are referred to case management primarily when they are hospitalized and in crisis.

At that time, the goal is to stabilize them and get them to a lower level of care. After discharge, the case managers work to find out what caused the problems.

"Nine times out of 10, it's lack of specialty care," Neslen says.

For instance, the patient may be an asthmatic with multiple prescriptions for oral medications and inhalers who doesn't know how to use them. He is going from one physician for one medication and another for another medication.

"The patient is set up for failure. They end up in the emergency room. They do much better if we get them to a specialist for their care," Neslen adds.

The case managers help chronically ill patients modify their behavior and learn to manage their own illness. They provide educational materials from specialty organizations such as the American Lung Association and the American Diabetes Association.

The case managers contact patients on a weekly basis when they are in crisis. They check to see if they are taking their medicines and if they have made scheduled physician visits.

As their condition improves, they call less frequently until the patients are stable and independent and their file can be closed.

Beech Street case managers typically handle 35-45 active cases at a time, based on the acuity

of the patient. For instance, a patient with a new spinal cord injury may require so much attention for the first few weeks that the case manager has a lower case load than her peers. ■

HMO touts DM programs from outside vendors

Contracting provides expertise in short time

When UCare Minnesota initiated its disease management programs, the Minneapolis-based HMO decided to use outside vendors instead of developing its own programs in-house.

The HMO has more than 100,000 members throughout Minnesota and serves Medicaid and Medicare members.

The HMO chose to use outside vendors rather than creating its own disease management programs because of the difficulty of creating a program and finding the expertise to staff it in a short time.

"We didn't have the in-house expertise or the capacity to have the type of thorough program we were interested in. The ability to build specialized disease management programs in a reasonable time is a major obstacle to health plans," says **Craig Christianson**, MD, medical director for state public programs.

One of the HMO's most successful programs is UCare Asthma Action, a disease management program for asthmatics administered by Matria Healthcare, an Atlanta-based disease management company.

The HMO is in the midst of completing a rigorous analysis based on claims experience, but quality of life surveys and a member satisfaction survey have had positive results.

"We often wait six months or more before receiving claims from hospitals. We're hoping that we will find significant reductions in hospital stays," Christianson says.

Members responding to quality-of-life surveys have reported reduction in missed days at school and work, he adds.

Asthma is a significant problem among UCare Minnesota's Medicaid population, particularly the inner-city population.

The asthma program went live in November 2000. There are 894 members enrolled in the care management portion who are actively managed by nurses in the call center. About 1,500 other members in the education-only program receive targeted mailings throughout the year, Christianson reports.

The UCare Asthma Action Program was one of eight UCare Minnesota programs spotlighted by The American Association of Health Plans (AAHP) in its national report "Innovations in Medicaid Managed Care: Health Plan Programs to Improve the Health and Well Being of Medicaid Beneficiaries."

The HMO chose Matria because its asthma management program already had experience in serving the Medicaid population, Christianson says.

The Matria program is conducted in conjunction with the National Jewish Medical and Research Center in Denver. The center, originally a respiratory disease hospital, has specialized care managers who call UCare members in the asthma management program.

"The case managers at National Jewish do exactly what we would do for the patients if we have the capacity to do it in-house," says **Mary Deering**, RN, MPH, manager of disease management for UCare Minnesota.

The case managers at National Jewish Medical and Research Center work closely with the UCare case managers to manage complicated cases.

"Members are not necessarily aware of the split. The UCare Asthma Action program is designed to be a seamless system of care for the member," Deering adds.

Here's how the program works:

Matria identifies likely candidates for the asthma program using claims data and other information from UCare. Once the participants are chosen for the program, the National Jewish Medical and Research Center staff takes over.

The Asthma Action case managers do a thorough assessment of each participant and stratify them based on their severity. They make sure the members have an asthma action plan in place, send them a peak flow meter, and encourage them to measure their peak flow, to learn to recognize what triggers their symptoms, and to work with their physicians.

If a member's disease warrants it, the UCare case managers arrange a home visit by a home care nurse who does an environment assessment and makes recommendations for changing the home environment or provides patient education in the home.

The home care nurses are on the staff of home

care agencies selected by UCare and were trained by National Jewish Medical and Research Center, who sent a nurse to Minneapolis to conduct the training.

The disease management case managers offer training and educational materials to physicians, including information on appropriate asthma management medications, and operate a free physician consultation line that physicians can use if they have a problem case.

"One of our initial concerns about using an outside vendor was involving a third party in the mix between provider and member. We haven't had any complaints from the providers," Christianson says.

"The program is attractive to members as well as to physicians," he adds.

As an adjunct to their case management program, young UCare members with asthma are eligible to participate in a summer camp sponsored by the Minnesota Chapter of the American Lung Association.

The program has been available free for UCare members for some time, but interest has increased since the Asthma Action disease management program began.

"The number of members who took advantage of the program this year has doubled or tripled. It's a fun place for the kids, but they also learn how to manage their asthma, and it reinforces what we teach them throughout the year," Deering says.

The HMO uses an outside vendor for its end-stage renal program and has a congestive heart failure program that is jointly operated by an outside vendor and a network clinic.

The company uses an outside source for telephone calls to its pregnant members.

"We are trying to help identify early on the risk factors that can affect the outcome of a pregnancy. With Medicaid patients, identifying the problem is often delayed to the point where we see adverse outcomes," Deering says.

The outreach calls are handled by the outside vendor, but the UCare case managers also communicate with the patients. ■

Health plan, vendor work on problem solving

Medicaid population offers unique challenges

Case managers who deal with Medicaid populations face a number of challenges they don't encounter in a commercial population.

And Medicaid patients with chronic diseases are among the toughest in health care to manage.

"Our members have chaotic lives. They can't get in for a physician visit or get their kids in for a physician visit because of some other event occurring in their lives. It makes them a complex population to manage," says **Mary Deering**, RN, MPH, manager of disease management for UCare Minnesota, a Minneapolis-based HMO.

That's why managing the Medicaid population is a collaborative effort between UCare Minnesota's in-house case managers and Matria Healthcare, the vendor that manages the UCare Asthma Action disease management program.

There is a constant turnover in the UCare Medicaid population as members lose eligibility when they get a job or move.

"Getting in touch with the people is the key problem in a disease management program for this population," Deering says.

For instance, the phone numbers are missing or not in service for about 40% of the UCare members.

Keeping track of Medicaid patients can be a logistical nightmare.

Some Medicaid patients don't have permanent homes. Many of those who do can't afford a telephone or they move frequently.

UCare has developed in-house systems to make sure the telephone numbers and other data on the members is accurate. The customer service departments and the clinics that treat UCare clients help track down people with incorrect phone numbers and help get them reconnected with the HMO.

The diversity of UCare's Medicaid population presents another challenge to case managers.

"Our Medicaid population includes a wide range of people who have difficulty navigating the health care system. We have a lot of members who are limited in their proficiency in the English language and who are totally unfamiliar with the American health care system," Deering adds.

The Asthma Action program is administered by Matria and staffed by nurses who specialized in respiratory care at National Jewish Medical and Research Center in Denver. "One of the reasons we chose Matria and National Jewish is that they have the expertise in working with non-native English speakers," Deering adds.

The program uses educational material written

on an elementary school level with a pictures and simple ideas.

When the case managers at National Jewish call patients and pick up complex psychosocial situations or other disease conditions that may be interfering with treatment, they involve UCare's case managers to help manage the care.

"We encourage two-way communication between our on-staff case managers and those at National Jewish. Their expertise is in respiratory care management," says **Craig Christianson**, MD, UCare's medical director for state public programs.

For instance, one participant in the asthma management program had significant psychosocial problems. National Jewish case managers got the UCare case managers involved to get her connected to mental health services. ■

How to deal with out-of-state patients' last wishes

Advance directives may not be valid in your state

Here are some scenarios you may encounter as a case manager:

- **A patient has terminal cancer and comes to your city to live out his last days with his daughter.** He has a living will, but his daughter is reluctant to follow it. How do you make sure his final wishes are carried out?
- **An elderly patient is traveling through your state or visiting on vacation and has a heart attack and is unconscious.** How do you determine who makes the health care decisions for the patient?

These situations are complicated by the fact that the patient resides in one state and is sick in another. And because each state's laws are different, it may be difficult to enforce a living will or health care power of attorney signed in another state, points out **Stuart Brock**, CCM, JD, an associate in the insurance, governmental, and tort litigation practice group of Womble Carlyle, a Winston-Salem, NC, law firm.

Case managers in certain parts of the country often must manage the care of someone from a different state with different laws.

For instance, a case manager in Florida or somewhere along the I-95 corridor is likely to encounter "snow birds" who have a heart attack or illness on their way to and from their Florida homes.

Since people are governed by the laws of the state in which they receive treatment, this could pose a problem with patients' legal documents.

In these cases, a patient's living will or health care power of attorney may be invalid, depending on the laws of the state in which they are receiving treatment.

"Case managers have a legal obligation to make sure their patients' choices are honored. It may be difficult to carry out the patients' wishes in these cases, especially if there is a contentious family member," Brock says.

When Brock spoke on legal issues in elder care at the Case Management Society of America conference in June, he encountered story after story of horrible end-of-life situations that could have been avoided.

"It's really troubling when there are four or five family members and some want one thing and the others want another," Brock says.

If a case manager in any setting encounters someone from out of state, he or she needs to know that the patient generally is covered by applicable laws in the state where he or she is being treated.

During the initial visit, the case manager should ask the patient if he or she has advance directives or, if they are unconscious, ask a family member for the documents. If the documents are at the patient's home, ask to have them forwarded to you.

"Case managers must deal with delivering services in a way that is consistent with the patient's best interests. Sometimes the choices of the patient and the patient's family do not coincide," Brock says.

That presents a problem that is complicated when the patient does not have legally constituted advance directives in place, which could minimize problems with a patient's last wishes.

Brock suggests asking any out-of-state patients whose case you manage how often they are in your state. If it is likely they may encounter a similar situation, be proactive and educate them about what they need to do to protect themselves, he adds.

That way, they can take care of their advance directives following your state laws so next time they become ill in the state, they're protected.

Do your in-state patients a favor and let them know that their advance directives may not be valid in another state. That way, if they have a

vacation home or often visit grandchildren in another state, they can prepare advance directives according to that state's laws as a backup. ■

Be careful in disputes during end-of-life

Risk management can help you deal with families

When there is an emotional situation, such as a life-threatening injury or illness, family behavior can be unpredictable.

As a case manager responsible for coordinating patient care, you could find yourself in the middle of a family dispute on what steps should be taken to care for a dying relative.

If you know the patient's wishes and the family doesn't want them carried out, you, as a case manager, are bound to follow the patient's wishes, asserts **Stuart Brock**, CCM, JD, an associate with the law firm of Womble Carlyle based in Winston-Salem, NC.

That's why case managers should take a proactive approach with patients, especially if they are elderly, to make sure they have advanced directives in place to avoid legal hassles and family squabbles over their last wishes, Brock advises.

In the best-case scenario, when a patient is in critical or terminal condition, a case manager will assemble the patient's advance directive documents and put them in the file. If you can't do that, document that you have had the discussion with the patient or the next of kin, Brock advises.

Even if the documents are in place, family members may balk at carrying out their relative's living will. In other cases, you may encounter questions of whether or not the patient has the capacity to make a decision about his or her health care.

Your risk when issues of advance directives arise vary with your practice areas, but if you are involved in direct care and the care is not consistent with the patient's choices, you could be at risk and so could your organization.

"We are living in a litigious society, and health care costs are soaring because of malpractice costs and the cost of litigation. Of course, case managers act in the best interest of their patients, but they also must manage the risk to themselves and their organizations. They can't serve their clients if they aren't operating as an entity," Brock says.

If it appears that there may be a dispute about end-of-life care for a patient, immediately ask the risk management department of your organization to become involved. The risk managers can guide you through the legal system and get the courts involved if necessary, Brock says.

Involve social workers to work with the family and help deal with issues before they become volatile, he suggests.

Use your case management skills to smooth things over initially and then involve the next level, which is risk management. You don't want to be alone in these situations, Brock says.

"Case managers don't want to be making decisions without involving the family as much as they can. Case managers can usually assess early on the family dynamics and can begin the education and diplomacy process," he says.

Keep in mind that case managers are being named among the defendants in more and more lawsuits and must take steps to protect themselves and their organizations.

"In the current litigious state of our societies, case managers, as a part of an interdisciplinary practice, can be affected in many ways by malpractice lawsuits," Brock says. ■

Take proactive steps to avoid legal disputes

Educate yourself so you can educate your patients

Ensuring that advance directives are in place for all patients presents an opportunity for case managers to meet a need and help ease families through a difficult time, says **Stuart Brock**, CCM, JD.

"I can't imagine what it would be like to be a layperson and be faced with those documents and legal terminology for the first time when I just learned that someone very close to me is in a situation that requires them," adds Brock, an associate with the law firm of Womble Carlyle based in Winston-Salem, NC.

If you deal with elderly patients, you should find out if they have a will and if they have advanced directives such as a living will and a health care power of attorney that name someone else to make medical decisions if the patient can't make them themselves. **(For definitions, see box, p. 116.)**

• **Make sure your elderly clients have planned their health care choices and have in**

Legal documents elderly patients should have

- **Living will**: A living will is a declaration that you desire to die a natural death. It states that you do not want extraordinary medical treatment or artificial nutrition or hydration used to keep you alive if there is no reasonable hope of recovery. A living will gives your doctor permission or withholds or withdraws life support systems under certain conditions.
- **Health care power of attorney**: A document that allows someone else to make medical decisions for you if you cannot make them yourselves. Requirements and laws vary from state to state.
- **Durable power of attorney**: This document gives someone the legal authority to act for you. A durable power of attorney is effective even if you are incapacitated. A regular power of attorney ends if you are incompetent of incapacitated. ■

place the mechanism to have their wishes carried out.

When you talk to your clients about other issues, ask them simple questions such as "do you have advanced directives in place?" Help them begin to formulate some of the questions they should ask and issues they should look out for.

"Don't expect to reinvent the wheel overnight. Just get the ball rolling. We often miss out on opportunities to bring things up because of our hectic lives. But case managers need to bring up these subjects in their encounters. It will minimize the possibility of risk over time," Brock says.

• Contact the various elder care agencies in your area and educate yourself on end-of-life legal issues in your state.

Brock suggests using local resources such as the cooperative extension service, which may operate a community clinic, local law schools that sponsor elder clinics and other aging and senior services.

• Read as much as you can and learn the local laws that are important to you.

"Case managers should educate themselves, read as much as they can and learn the local jurisdictional difference that are important to them," Brock says.

• Look at how you assess patients and decide whether you need to include additional questions.

The information can be extrapolated to any decision where a patient's competency will be questioned or when they are facing the risk of death, such as with major surgery or cardiovascular events, Brock adds.

"I cannot think of a single instance when someone encountering the health care delivery system wouldn't want to put these documents into place," he adds. ■

Case managers: It's your week to shine

Plan activities to showcase your profession

Case Management Week, Oct. 6-12, is a good opportunity for case managers in all settings to educate the public and the health care community about the vital role case managers play, says **Karen Chambers**, RN, CCM, CDMS, associate director of the Medicaid maternity program for VIVA Health in Birmingham, AL, and national president of the Case Management Society of America, based in Little Rock, AR.

"Case managers come from a variety of educational backgrounds — nurses, social workers, therapists — and work in a variety of settings. Case Management Week is a time for all case managers to join together to celebrate the profession, she adds.

Chambers calls on all case managers to come up with ways on the local level to honor case managers and educate the public on their role in health care.

"One of the biggest problems is that few people understand our role because so many people call themselves a case manager. Some people think of case managers as a gatekeeper, but there's also the patient-advocacy piece," adds **Peter Moran**, RN, CM, BSN, MS, CCM, a nurse case manager in the emergency department at Massachusetts General Hospital in Boston, past president of the New England Chapter of CMSA, and now a member of the national board of directors.

As part of the New England chapter's efforts to commemorate Case Management Week, Moran has spoken at local hospitals to employee groups that include the chief executive officer, chief financial officer, and board members. He was interviewed about case management by a local cable television station for a program that

aired five times a week for a month.

The chapter offers a program in the workplace to explain the case managers' role, case management standards of practice, and the challenges ahead.

"It's got to start as a grass-roots effort to break down the barriers and help improve the communications flow," Moran says.

For instance, in 2000, the Tennessee chapter wrote a proclamation for Case Management Week that was signed by the governor. Last year, seven chapters got similar proclamations issued by the governors in their states.

Spread the word

A project to commemorate Case Management Week doesn't have to be elaborate or expensive, Moran says. You can just set up a table at your workplace and pass out information and answer questions.

Volunteer as a speaker at your local civic organizations, such as the Rotary Club, Lions Club, or the PTA. Tell them that if they have a catastrophic illness, they should ask for a case manager to help them through it.

"At this point, we're trying to tell people what case management is and let them know that if somebody is stuck in the system and not sure what is going on, they should ask to speak to their payer's case manager or the case manager of the health care facility," Moran says.

The Case Management Society of American compiled a list of activities held in honor of Case Management Week last year. Here are a few of them:

• BlueCross BlueShield of Arkansas sponsored its third annual case management recognition day that included an all-day educational program including speakers, vendors, and lunch. As part of the entertainment and education, **Kathleen Moreo**, past president of CMSA, hosted a case-management version of the TV quiz show "The Weakest Link."

• The Central California Chapter of CMSA hosted receptions for case managers and others in three different cities. Activities included chat sessions about case-management issues, the certification process, and other topics, refreshments, presentation of membership pins to CMSA members, and a raffle of T-shirts and other gifts.

• "Enhancing the Relationship Between Physicians and Case Managers was the topic at the regularly scheduled monthly meeting of the St. Louis chapter. Four physicians were invited to sit on a panel and respond to questions relating to their experiences and perceptions of case management, how case managers could benefit their practices, and recommendations for enhancing the physician/case manager relationship.

• A "Fun-and-Learn Case Management" celebration, sponsored by the Delaware chapter in Newark, earned CCM contact hours for all participants in the case management version of the game show "Jeopardy." Those attending enjoyed dinner and a gift.

• A "Bring a Friend in Case Management" luncheon was the project of the Bay Area CMSA chapter in Panama City, FL. The celebration, held during the regular monthly meeting, included special recognition for each member.

For more information on Case Management Week projects, see the CMSA web site at www.cmsa.org. ■

CM could benefit as employers turn to HRAs

Plan could help people take charge of their care

The recent approval of employer-funded Healthcare Reimbursement Accounts (HRAs) by the U.S. Department of Treasury will give employers and employees more flexibility in health care coverage and may actually make the case manager's job easier, says **Bonnie Whyte**, CSCI, spokeswoman for the Employers Council on Flexible Compensation, a trade association based in Washington, DC.

HRAs, also known as defined contributions to health care or flexible spending accounts, allow the employers to fund personal accounts that can be used to reimburse workers for out-of-pocket medical expenses, including premiums and deductibles.

Under the guidelines issued by the Internal Revenue Service in June, employees do not have to pay tax on the HRA contributions by their employers, and the money can carry over from year to year if it isn't spent.

Until the recent IRS ruling, the only flexible spending accounts allowed expired after one year if the money wasn't spent. As a result, at the end of the year, employees often bought extra pairs of eyeglasses or arranged for various tests and procedures

that were not necessarily the most efficient use of health care funds, Whyte says.

Here's how the HRAs work: An employer chooses a health insurance plan with a high deductible and puts a certain amount of money in an HRA for each employee covered by the policy. The employee can use that money for any expenses not covered by his or her health insurance plan. It could be used for the copay, the deductible, or to go to an out-of-plan physician. HRA funds can even be spent on long-term care insurance, Whyte says.

"The only things people can't do with their HRA is to cash it out," she adds.

When money isn't used in one year, it can accumulate and be available down the road if the employee incurs significant medical expenses, she says.

HRAs could significantly improve the case manager's job, particularly in dealing with chronically ill patients, because what the patient does will affect their pocketbook, and although the money is available, it benefits them not to spend it, Whyte says.

"When people see that the money is coming out of their pocket, they are going to realize that medical care is not free. They are going to be more interested in keeping their diabetes under control or doing their physical therapy exercises at home instead of going for an extra session, because what they spend today will affect the money that could be carried over into future years," she explains.

Whyte doesn't see much change in how catastrophic injuries or illnesses will be handled or how their cost will be affected.

"But when it comes to day-to-day chronic care, people are likely to be far more interested in having the proper care than they might have been under first-dollar coverage," she says.

"Assuming that they've saved up money over time, the money can pay for some of the oddball problems they run into that may not be covered," she adds.

Employers will be likely to embrace the new HRA plans as a way to deal with the increasing costs of insurance premiums, the experts agree.

"Many employers are attracted to these plans because they offer a break with past practices and take a step toward making employees more responsible for their own health care decisions," says **Helen Darling**, president of the Washington Business Group on Health.

Will the move to "defined contribution" to health benefits keep medical care costs from soaring? The experts disagree.

HRAs can help reduce costs

Research by Watson Wyatt Worldwide and the Washington Business Group on Health Institute on Health Care Costs and Solutions indicate that the HRAs can successfully reduce both short-term and long-term costs.

On the other hand, a new report by the Employee Benefit Research Institute (EBRI) concluded that the ability to control costs would be limited. The reasons:

- Technological innovations in health care account for between 49% and 65% of increases in health spending, while the comprehensiveness of insurance accounts for 10%-13%.
- While consumer-driven health benefit approaches may result in more efficient spending, overall costs may not go down since the majority of health care expenses are incurred by a small percentage of those covered. For instance, 10% of the adult population with employment-based health insurance accounted for 58% of all health care spending in 1998. ■

Diabetics, providers have different perceptions

Diabetes is most effectively treated when patients and clinicians work closely together as a team but the team members seem to have different perceptions about the disorder and its treatment according to research presented at the American Association of Diabetes Educators annual meeting in Philadelphia in August.

"We found major differences in the way patients and health providers view diabetes and its treatment," says **Mark Peyrot**, PhD, lead investigator and professor of sociology at Loyola College in Baltimore.

For instance, patients rated their adherence to treatment higher than did nurses or physicians, and physicians underestimated their patients' fear of low blood glucose.

"We believe treatment outcomes could be improved if health professionals increase their awareness and understanding of these differences and take them into account in their communications with their patients," Peyrot adds.

Patients who had a better initial reaction to being diagnosed with diabetes adjusted better and had an improved quality of life, the study shows. "Clinicians should identify patients who respond poorly to the diagnosis of diabetes since they may be at higher risk for later problems," Peyrot says.

Other results of the study were:

CE questions

For more information on the CE program, contact Customer Service at (800) 688-2421.

13. Beech Street Corp., based in Lake Forest, CA, contracts with more than how many specialty care facilities?
    A. 50,000
    B. 60,000
    C. 70,000
    D. 80,000

14. UCare Minnesota's Asthma Action program is administered by what disease management company?
    A. McKagen Consulting Services
    B. Beech Street Corp.
    C. Matria Healthcare
    D. It is self-administered by UCare.

15. A living will is a document that allows someone else to make decisions for you if you cannot make them yourself.
    A. true
    B. false

16. What are the dates of Case Management Week 2002?
    A. Nov. 3-9, 2002
    B. Sept. 22-28, 2002
    C. Dec. 1-7, 2002
    D. Oct. 6-12, 2002

Answers: 13. A; 14. C; 15. B; 16. D.

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Editorial Questions

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

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• Nurses identified patients' personal problems, such as financial pressures and transportation difficulty, as having a greater impact on glucose control than did physicians.

• Nurses tended to help patients with their daily routines to encourage compliance, while physicians more often used medical information and threats.

• The nurses' views on the psychosocial aspects of the disease were closer than the physicians' views to the patient views.

The study was part of a larger international study called DAWN (diabetes attitudes, wishes, and needs), which addresses attitudes and perceptions of more than 5,000 people with diabetes and 3,000 diabetes health care professionals in 13 countries. For more, go to www.dawnstudy.com. ■

Audio conference clarifies final EMTALA regulations

The final version of the recently proposed changes to the Emergency Treatment and Labor Act (EMTALA) is expected to become effective on Oct. 1. Issues in the final regulations could include changes to physician on-call requirements, "comes to the emergency department" definitions, later-developed emergencies, non-hospital entities, and prior authorization. With all the confusion surrounding the proposals during the past year, make sure you know what it takes to comply with the final regulations.

To keep you on track, American Health Consultants (AHC) offers the **EMTALA: Complying with the Final Regulations** audio conference, scheduled for Tuesday, Nov. 12, 2002, from 2:30 to 3:30 p.m. ET. The conference will be presented by **Charlotte S. Yeh**, MD, FACEP, and **Nancy J. Brent**, RN, MS, JD. Yeh is medical director for Medicare policy at National Heritage Insurance Co. in Hingham, MA. Brent is a Chicago-based attorney, with extensive experience as a speaker on EMTALA and related health care issues. In June of this year, both speakers presented **EMTALA Update 2002**, one of AHC's most successful audio conferences.

Each participant can earn FREE CE or CME for one low facility fee. Invite as many participants as you wish to listen to the audio conference for $299, and each participant will have the opportunity to earn 1 nursing contact hour or 1 AMA Category 1 CME credit. The conference package also includes, handouts, additional reading, a 48-hour replay of the live conference, and a CD recording of the program.

For more information, or to register, call customer service at (800) 688-2421 or (404) 262-5476, or e-mail customerservice@ahcpub.com. When ordering, please reference effort code: **63221**. ■

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. ■