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INSIDE

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How to face down ethical dilemmas in case management

Remember, your primary role is being an advocate for the patient

If you're a typical case manager, you are faced with ethical dilemmas several times a day. "The job is pressure-filled. Case managers are under pressure from insurers to contain costs, from employers to return people to work. They may be working with other health care professionals and don't think they are acting ethically. They have a lot of daily dilemmas to work through," according to **Susan Gilpin**, JD, chief executive officer of the Commission for Case Manager Certification (CCMC) in Rolling Meadows, IL.

Here are some ethical issues you may deal with:

• A workers' compensation client clearly is not ready to return to work, but his employer, who has hired you to manage the case, is pressuring you to send him back. Should you give in to pressure?

• A client needs to go to an extended care facility after hospitalization, and a bed in an excellent facility is available in two days, but the insurance company you work for wants the patient moved from the hospital immediately. Should you move her to a less desirable facility in order to save two days in the hospital?

• You're working with a patient who was injured and you find out, coincidentally, that the person has cancer, a condition that could affect his insurability and his employment. Should you notify his employer or

Do you have an ethical question?

Beginning next month, representatives of the Commission for Case Management Certification will begin a new column that answers your questions on ethical issues facing case managers today. If you have an ethical question or concern, fax or e-mail it to Mary Booth Thomas, (770) 939-5823 (fax); e-mail: marybootht@aol.com. ■

his insurance company?

The primary role of the case manager is to be a patient advocate. While case managers are accountable to different stakeholders — employers, insurers, physicians — the patient's well-being should be their first consideration, says **Mindy Owen**, RN, CRRN, CCM, chair of the ethics committee and a member of the executive board of the CCMC.

"If we look at it from an ethical standpoint, keeping in mind our advocacy role, we should think about: If this was my mother, my child, or my husband, is this the way I would want it handled?" Owen adds.

The biggest part of an ethical decision is differentiating to whom the case manager owes his or her allegiance, Gilpin points out.

"In the best of all worlds, everybody wants what is best for the patient and there is no conflict, but that's not always the case," she adds.

Case managers sometimes have to rely on their own intuition and moral compass to get a sense that there is something wrong, Gilpin says.

In the case of being pressured to return a patient to work or to move him or her too quickly to another level of care, the case managers' loyalty clearly should be to the patient, she adds.

Gilpin notes a conference during which one person told of coordinating care for an injured patient. Because of the nature of the person's disability, she knew that the patient was covered by the Americans With Disabilities Act but didn't feel it was her duty to the patient to let him know, she says.

"It was interesting to see people react to this because they knew it was wrong. Most of the people at the conference knew she had a role to play to advocate for the person but withheld it because she thought it would anger the employer who was paying her," Gilpin says.

Case managers who are under pressure to maintain the cost of treatment might be reluctant to mention to a patient that there is another test the physician should have performed on them, she adds.

There are instances where the person receiving services from the case manager doesn't understand the case manager's role and doesn't understand what the case manager has to disclose and to whom.

There are instances where the case manager may be working directly for the employer or the insurance company and the client thinks the case manager is working only for him or her.

"These are instances where the case manager needs to clearly explain his or her role to the individual receiving services at their very first meeting. There should be no misunderstanding of what the case manager can do and can't do with regard to what insurance will cover and to whom they report what information," Gilpin says.

Case managers doing things that are not in their scope of practice is one of the most prevalent ethical problems, Owen adds.

"Case management is an advanced practice and one that is fairly new in the health care practice arena. There is an assumption by the public that we can do things that aren't in our scope of practice," she says.

For instance, case managers may step over the

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Editorial Questions

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

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bounds by making decisions in terms of medical treatment.

"They can recommend, but sometimes they go beyond just recommending because they believe they are in a position to be a decision maker of medical treatment. I believe strongly that this is not the role of the case manager and not what they are trained to do," Owen says.

If case managers truly want to design a medical treatment plan, they need to go to school and become a physician. If they want to help the physician with health care issues around the treatment plan that falls within the scope of practice, they are on the right track, she says.

Case managers should be concerned about and report to physicians about safety issues, environmental issues, and financial issues, all of which revolve around medical treatment, but they absolutely should not order drugs or treatments, Owen says.

"This doesn't happen in a malicious or neglectful way, but sometimes case managers are put into those positions, especially in the insurance arena, by the job or the position they hold. I'm not sure it's in anybody's best interest," she says. ■

How to know when you're facing an ethical dilemma

Consult supervisor, peers, CCMC for assistance

When you're confronted with an issue that just doesn't feel right, ask yourself: Am I truly doing the right thing at the right time for the right reason?

If the answer is yes, you're probably making an ethical decision, says **Mindy Owen**, RN, CRN, CCM chair of ethics committee and a member of the executive board of the Commission for Case Manager Certification (CCMC).

In all cases, whether you're a nurse, a social worker, or a therapist, follow your professional scope of practice and professional code of conduct, she advises.

All case managers should take time to review the Code of Professional Conduct issued by the CCMC, suggests **Susan Gilpin**, JD, chief executive officer of the CCMC.

"It's not designed to be a punitive weapon but a measure that gives case managers guidance when they face something that doesn't feel right," she says.

If there is any question about the scope of practice or code of conduct when case managers think they are being asked to overstep the bounds, they should start by raising the issue with their supervisors, Owen advises.

Even if they don't get the answer that makes the situation feel right, if the issue arises in the future, they can say they consulted with their supervisor and were told to follow a certain direction, she adds.

Consult other CMs

Consult other certified case managers to see how they handled a similar situation.

"In the cases of ethical dilemmas, case managers often get their best help from peers who have faced the same question," Gilpin says.

Once case managers have reviewed their scope of practice within their work environment, if they still have questions, they should bring it to the commission for review, Owens says.

"It goes back to doing the right thing at the right time and for the right reason," she says.

The CCMC hasn't received a large number of complaints against case managers concerning ethical violations. However, the CCMC does receive requests for advisory opinions from case managers in the field who aren't sure what the right direction is, Gilpin says.

"In those instances, the case manager has already gone to their supervisor and discussed the issue with their peers but they still don't feel comfortable," she says.

When case managers have explored all the avenues open to them and still feel they aren't doing the right thing because of workplace pressure, they have to ask themselves if theirs is a job they can live with or should they move on.

"It's not an easy issue. You can't look at it as a black-and-white issue. There are a lot of pressures placed on case managers in the decision-making process. But this is something we as case managers need to consider," Owen says.

What are the consequences of unethical behavior? If someone files a complaint against you, your certification can be revoked and the state licensing board notified. You also could be sued.

"The upside of practicing ethically is that, in the long run, case managers are providing better care to individuals. It's a great risk-management tool to keep them out of legal problems," Gilpin says. ■

Confidentiality may involve sticky legal, ethical issues

Think before you share patient-sensitive information

When it comes to confidentiality issues, case managers often walk a tightrope, **Mindy Owen**, RN, CRRN, CCM, asserts.

Case managers have to be careful about what kind of information they share with family members, insurers, employers, and even people who provide outside resources, adds Owen, chairwoman of the ethics committee and a member of the executive board of the Commission for Case Management Certification (CCMC) in Rolling Meadows, IL.

"One of the key skills of a case manager is effective communication, and 90% of communication is listening. Being a good listener means being able to figure out what is necessary to move the case forward and what is their accountability in terms of confidentiality," Owen says.

In addition to looking at ethical issues before they share information, case managers must be aware of the Health Insurance Portability and Accountability Act (HIPAA) rules and regulations and how that will affect their practice.

"Case managers are working with health care issues that revolve around medical treatment. So many times they are working with ancillary or adjunct resources that want information on their clients in order to provide a wheelchair or set up a financial account. Case managers have to be careful about what information they give out because of privacy issues," Owen says.

For instance, a payer is having its bills paid by an outside firm that audits the file and pays the bills. The firm requests a copy of the case file for an individual patient.

Without thinking, a case manager may go ahead and send in the information to make sure the bills get paid, but he or she would be sending confidential information to someone who is not a part of the health care team, points out **Susan Gilpin**, JD, chief executive officer of the CCMC.

Workers' compensation includes many confidential issues around medical care and treatment and how much information goes back to the employer.

A case manager could be working with a worker who is injured on the job but finds out that the employee has cancer. The employer has the right to know about the injury but does not have the right to know about the cancer.

The issue is a sticky one even in the case of an injured employee who has a potentially contagious disease.

Case managers have to be careful what information they share with the employer. If a case manager is working with someone and reporting back to the insurance company, the same kind of issue may arise if the case manager finds out something that is not directly related to the case for which he or she was hired but that could affect the individual's insurability.

Confidentiality issues also arise when case managers work with a family. For instance, a patient may not want her husband or children to know about her disease.

Computers raise another confidentiality issue that could have implications if ethical issues arise.

Owen tells of a case manager working with a psychiatric patient who did not agree with the psychiatrist's treatment plan and wrote notes to that effect on her computer.

However, she did not take her concerns up the chain of command. The patient committed suicide. The family sued not only the insurance company but also the case manager for not following procedure in raising questions about the patient's care.

"It goes back to the idea that if it's documented, it happened and if it isn't documented, it didn't happen," Owen says.

Keep in mind that you are not the only one who will read the notes in your computer. Computers can be subpoenaed as easily as hard copy files. ■

Initiatives target publicly insured young people

Case management programs begin with pregnancy

A series of case management initiatives to improve the health of their publicly insured young populations has paid off for Horizon/Mercy.

On the heels of its successful program to provide better prenatal care for its pregnant Medicaid recipients, the Trenton, NJ-based insurer initiated programs to increase immunizations among toddlers, lower the blood lead levels in youngsters, and educate sickle cell patients. Here are some of the results:

- In the first year of the insurer's Moms GEMS

(Getting Early Maternity Services) prenatal program, only 5% of members in the program had premature babies compared to 13% of the non-GEMS population. The GEMS program babies spent a total of 394 days in the neonatal intensive care program compared to 529 total for the babies of mothers not in the program.

• In the first year of the Children's Health Assessment, Maintenance, and Preventative Services (CHAMPS) program, which offers support and education to mothers of children from newborn to age 2, the HEDIS figures for well-child visits and immunizations increased by 17%.

• Following just six months of intensive case management for members with high levels of lead in their blood, the average level of the group tracked dropped from 20 to 16.

Horizon/Mercy covers 278,718 members, representing 42% of the state's total managed care market for the publicly insured.

The health plan's vision is to help its members learn to navigate the health care system and access the care they need, says **Pamela Persichilli**, RNC, director of clinical operations for Horizon/Mercy.

The members have access to an extensive network of pediatricians, primary care physicians, and nurse practitioners.

Part of the educational process is teaching the mothers that, under the Horizon/Mercy plan, they have access to a pediatrician office and don't have to use the emergency room when the child is sick, that they can see a specialist before their sickle cell disease gets so severe they are hospitalized, and that they don't have to wait for hours at a clinic for shots.

"We have the responsibility to teach them how to access care through their managed care organization. Once you educate someone on how to navigate the health care system, it's amazing how much happier they are knowing that they can make an appointment and go when it's convenient for them and not have to wait four hours in a clinic," Persichilli says.

The health plan regularly sends out flyers in various communities, inviting its members to "baby showers" held at a local hospital. The occasions give the members a chance to meet their case managers in person and provide them with information about all of Horizon/Mercy's programs for mothers and their children.

Case managers face a number of challenges in dealing with the Medicare population. They frequently encounter disconnected telephones, address changes, wrong addresses, and members who change health plans frequently.

"In the CHAMPS program, we typically reach about 30% of our membership every month. This is about an industry standard with the publicly insured," says **Giavanna Ernandes**, RN, MSN, APNC, team leader for disease management. She is in charge of the provider's CHAMPS program, the lead level monitoring department, and the sickle cell disease, diabetes, and congestive heart failure programs.

Under New Jersey law, Medicaid managed care members can change plans every month, and many of them choose to do so.

"That is our single most frustrating issue. If they don't fill out the paperwork or decide to try another plan, we lose track of what immunizations the baby has had," Ernandes says.

The case managers don't give up with just one telephone call. They make an effort to keep up with the members.

When the case managers receive information that a member has disenrolled, they call the member and make sure he or she is in another plan.

Horizon/Mercy's social workers assist in coming up with creative ways of finding members whose telephone numbers and addresses are wrong. They call the pharmacy to see if the members have had prescriptions filled, call the primary care physician to see if they have a different address, and check state Medicaid rolls for a better address.

"We send them as many as three letters asking them to call us back so we can keep up with their child's health. We try several avenues before we close a case," Ernandes says. ■

Program stresses childhood immunizations

Case managers educate publicly insured mothers

Before Trenton, NJ-based Horizon/Mercy started its Children's Health Assessment, Maintenance, and Preventative Services (CHAMPS) program for publicly insured mothers with infants, many of the mothers didn't realize the importance of getting immunizations and well-child visits for their children, says **Giavanna Ernandes**, RN, MSN, APNC, team leader for disease management, including the CHAMPS program.

"A big piece of our work is parent education. Many of the mothers didn't understand that they

had an insurance plan that would allow them to use a pediatrician. Once you teach people who are publicly insured how to access health care, they are so grateful and relieved," she says.

The health plan started the CHAMPS program on the heels of its successful Moms GEMS (Getting Early Maternity Services) prenatal program. **(For details on the Moms GEMS program, see *Case Management Advisor*, July 2002, pp. 76-77.)**

"We were doing so well and so proud of the GEMS program, but realized that after our postpartum call, there was no continuum. The mothers who were so well supported during their pregnancy lost their safety net," says **Pamela Persichilli**, RNC, director of clinical operations for Horizon/Mercy.

The Horizon-Mercy staff realized that the new mothers still needed support after their babies were born to ensure that the infants got the proper checkups and immunization.

The CHAMPS program begins when the babies are 1 month old and follows them through age 2.

Members of Horizon/Mercy have about 6,000 deliveries a year. CHAMPS enrolled 4,600 new babies in its first year. The plan's HEDIS figures for well-child visits increased by 17% in the first year of the program.

When a woman goes through the Moms GEMS prenatal program and delivers a baby, her name is automatically sent to the CHAMPS department a month after delivery.

"We call the mother and begin the process of teaching them about the importance of immunizations, the various types of vaccinations their child needs, and when they need them," Ernandes says.

They match the mothers with pediatricians in their area, find out if there are barriers to getting the child to the physician, and arrange transportation if necessary.

"We ask about social and family issues and do whatever we can to help them," Ernandes says.

CHAMPS follows the Elk Grove, IL-based American Academy of Pediatrics' (AAP) immunization schedule for newborns.

"We tell the mother that their baby needs immunizations at two months, at four months, and so on, and that we will call them to remind them and tell them what shots the baby will be getting," Ernandes reports.

Horizon/Mercy offers incentives to the mothers who take their babies to the physician.

Each provider has a supply of CHAMPS cards that include the baby's name, birth date, and other demographic information, along with a list of immunizations and well-baby visits. The physician circles what was done that day, signs the card, and mails it back to Horizon Mercy.

Mothers who follow the immunization schedule receive a gift package as an incentive.

For instance, when they go for the first series of vaccinations at two months, they receive a gift packages with a baby bottle, bib, rattle, night light, and literature in English and Spanish about child safety from two to six months.

At six months, they receive a teddy bear, medicine cup, and more age-appropriate childhood safety information from the AAP.

The case managers work to build relationships with mothers who are in the CHAMPS program and to help them with whatever problems they are having. For instance, a CHAMPS case manager may help with an older child with asthma who is having problems getting to use his nebulizer in school.

"There are so many issues other than just the immunization. Our goal is to improve the experience they are having with the health care system. A lot of times when we help them with other social issues, we get more cooperation in getting the babies to the doctor for well visits. The case managers develop a trusting relationship with the members," Persichilli says. ■

Sickle cell program prevents ED visits, admits

Education, access to specialists are keys to success

In the first four months, Horizon/Mercy's sickle cell disease management had identified 111 members with sickle cell and started an education program to help them avoid a painful crisis and hospital admissions.

"Sickle cell is a high-cost disease with a lot of inpatient admissions. We think that by educating our members and linking them to hematologists, we can prevent unnecessary admissions," says **Giavanna Ernandes**, RN, MSN, APNC, team leader for disease management, including the sickle cell program.

Members are identified when they are hospitalized, visit the emergency room, or see a physician for the disease.

Ernandes expects that the winter months will

result in identification of far more members because sickle cell disease is exacerbated by cold weather.

When a member with sickle cell disease is identified, the nurse case manager calls him or her, or the parents if the member is a child.

The case managers follow up regularly with the sickle cell patients, depending on the level of severity.

They ask about how the disease affects the members, hospital admissions, episodes of severe pain, and what kind of medical care the member has been receiving.

They provide educational materials, follow up with the primary care physician or specialists, and contact the pharmacist to look at utilization of medication.

"We go over cases to make sure they are being managed appropriately and, if not, we try to find a better avenue for them," Ernandes says.

Recognizing triggers

The case managers arrange for the member to see a physician or nurse practitioner, and in some cases a hematologist or a pain control specialist if that is what he or she needs.

"It all goes back to the crux of our mission and vision. Before we started this program, those people had no idea they could go to a center of excellence for care. We provide transportation to get them there and hook them up to a physician who is a champion of their cause," says **Pamela Persichilli**, RNC, director of clinical operations for Horizon/Mercy.

People with sickle cell disease have misshapen red blood cells that make it difficult for enough oxygen to get to their tissues. When they are injured, sick, or exposed to cold, their bodies are under more stress and need more oxygen, but their tissues can't get it because of the misshapen red blood cells.

The case managers work with the sickle cell patients to recognize the things that trigger a crisis, such as being cold, patient falls, or certain illnesses. They see that they are immunized for flu and pneumonia because illness also can prompt a crisis.

They teach them to take pain medication at the beginning of an episode and to put ice packs on their joints rather than waiting for the pain to become so severe that they go to the emergency room or have to be admitted to the hospital.

"We also teach them to recognize the times when they definitely should call their primary care physician or go to the emergency room," Ernandes adds. ■

Lead levels plummet with intensive case management

Parent education is the key to initiative

When Horizon/Mercy compiled the six-month outcomes report for its program to reduce the level of lead in its young members' blood, the figures were so astonishing that the state epidemiologist monitoring the program checked them himself.

"It was amazing. In just six months, the lead level of members in the group we were monitoring had dropped from an average of 20 to an average of 16. It's all due to the impact of the provider, the public health department, and the parents working together," says **Pamela Persichilli**, RNC, director of clinical operations for the Trenton, NJ-based insurer.

New Jersey law mandates that any child in the Medicaid population with a blood level of 10 or above must be under case management.

Through an Internet link with the laboratory, the case management department is able to upload the members' lead levels into its computer system, which generates a list of members with elevated levels of lead in their blood.

In the first year, the system identified 955 members with levels of lead in their blood of 10 and above.

Members with a blood lead level of 20 and above receive intensive case management with monthly follow-up. Case managers follow up every three months with members with a level of 10 to 19.

If a child's blood level is 7 or above, the case managers notify the parents and educate them on how the child could be exposed to lead.

"Although this level isn't considered toxic, we feel like we should monitor it and make sure it's not going up," says **Giavanna Ernandes**, RN, MSN, APNC, team leader for disease management and the lead program.

The case managers make sure the children get checked every three months for lead levels.

They educate the parents about proper diet and possible causes of lead in the blood. They arrange for the public health department to check for lead in the paint, ductwork, soil, and water.

"We monitor the members' diet to make sure the children are getting high levels of calcium and iron that will help reduce the lead level. We encourage them to give their children cheese,

yogurt, and milk," Ernandes adds.

They instruct parents on avoiding lead exposure through simple measures such as hand washing.

"In many cases, the children are being exposed to lead in the soil outside. They are playing outside and putting their hands in their mouths," Ernandes adds.

When the program started, the average blood level of children in the program was 20. After six months of case management intervention, the average had dropped to 16.

"We have found that through education and follow up, the blood lead levels are coming down," Ernandes says. ■

Program gives members tools to manage own health

Members empowered with information

Thanks to BlueHealthConnection, a new integrated care management program, more than a million members with coverage through Blue Cross Blue Shield of Michigan have just one source for answers about their health care needs.

The Detroit-based insurer has unified health care services and functions formerly performed through a number of separate programs, enhanced them, and put them under one umbrella.

Instead of treating areas handling disease management, case management, and a nurse help telephone line as separate functions, the insurer has created a seamless program to help the members get the care they need at the level of intensity they need in the most efficient manner.

The insurer aims to empower members with information, to get it to them as early as possible, and to help support patient-provider relations with new tools and more information.

"Patients are the greatest pivotal point in terms of health care and how you improve it. To improve health, you have to drive it through the members. You can do this by educating them about their conditions early on. By empowering them and becoming their partner, you can ultimately improve their health outcomes," says. **Jann Caison-Sorey**, MD, associate medical director for preferred provider organizations (PPO) and care management.

The fact that BlueHealthConnection is a fully integrated program doesn't mean that everybody does everything, points out **Thomas Ruane**, MD, medical director of PPO and care management.

Instead, the program pools all the insurer's data and resources to help members navigate the health care system and to direct them to a level of assistance based on their individual need.

"Our program is designed to provide the right setting of care management for each individual," Ruane says.

Three main components

The program has three main components:

• Guided self-management, including wellness information and basic information about diseases, and symptom management. This is available to members through nurse counselors on the 24-hour nurse call line.

• Integrated case management and disease management programs to members who have or may develop high-risk chronic conditions.

• Complex case management services, both telephonic and on-site, to complex illness and injuries, including terminal conditions.

"We are spending a lot of time, effort, and energy to ensure that it is seamless for a member to move from one level to another, depending on their need," Ruane says.

The integrated program provides services in a non-HMO environment, focusing on members who have PPO or fee-for-service benefit plans, Ruane says.

Patients in PPO or fee-for-service plans don't have an assigned primary care physician or requirements for referrals to specialists. Consequently, the patients may be seeing multiple physicians and care may not be coordinated, Ruane says.

In these cases, since the insurer has data from multiple physicians involved in the case, the health plan is in a good position to have the best information about what interventions the patients have had and which ones they may need, Ruane adds

"We were looking at an opportunity to use data more effectively. We believed we could deliver a program that got to the member at the time [he or she] needed intervention," he says.

Members who have the most severe conditions are offered the opportunity to participate in the case management program, which is not disease-specific.

Nurses who previously handled disease management in traditional ways with a lot of intensive interaction and have become experts in certain clinical conditions are being integrated with the

Blue Health Line nurses to provide additional resources to support the patient as well.

"We are finding that the greatest opportunity for intervention doesn't necessarily involve just the case manager," Ruane says. ■

Redesign puts CM programs under one umbrella

Aim: Members to receive proper interventions

BlueHealthConnections, a care management program in use at Blue Cross Blue Shield of Michigan in Detroit, pulls together a lot of care management programs that have been in place for many years.

"We had case management, we had disease management for a few customer groups, and we had a nurse line. But we knew there was greater potential for the program if we could integrate these to reach more members in need," says **Kevin Kihn**, RN, project manager for medical care management.

The new program allows patients to move along the continuum of care as needed.

"It depends on the degree and circumstances of the case. If there is a need for more intense support services and coordination, then a patient with a chronic disease may be shifted from disease management to case management," says **Thomas Ruane**, MD, medical director of preferred provider organizations and care management.

The team is refining the best points in the spectrum of care where the various types of patient intervention should be done.

For instance, case management has remained a distinct component because of its complexity and the severity of the conditions being treated. Disease management and nurse outreach programs are becoming more integrated and typically focus on a particular condition.

The program concentrates on four diseases: diabetes, systemic heart disease, congestive heart failure, and asthma. The four conditions represent a significant amount of morbidity and mortality for the population, Ruane says.

"We decided to have our nurses who have been experts over the years in delivering components of the program to take all their knowledge and expertise, meld it with the expertise of specialized vendors to incorporate this wealth of knowledge into BlueHealthConnections. The idea is to seamlessly provide services that address everything from the simplest questions to the most complex problems," Ruane says.

For instance, if a member has diabetes that is severe enough for an intervention, he falls into case management.

The case managers talk to the member and the member's physician, coordinate a treatment plan, and work with the physician and the member to address his or her health care needs.

In the case of diabetics whose condition is not severe, case management of the interventions may be handled by other components of the program.

For example, the data may show a diabetic patient with coronary artery disease who is not on a lipid program. In this case, a disease management nurse would arrange for the patient to get his cholesterol check and work with his primary care physician to see that he gets treatment.

"Nurses in a disease management program or in a health-line type of setting can effectively deliver those kinds of messages," Ruane says.

In the case of a diabetic with a wound that won't heal, the nurse counselor who answers the 24-hour call line may be able to give the member suggestions and turn the case over to the disease management nurse if it seems warranted.

"We're available to answer questions, and we try to develop a relationship with members. We might asks if it is OK if we give them a call in a couple of days to see how things are going," Kihn says. ■

Integrating CM was a long, complicated process

Insurer decided to create the program in-house

Before Blue Cross Blue Shield of Michigan developed its BlueHealthConnection representatives of almost every department in the company spent considerable time deciding exactly how to integrate all of the Detroit-based insurer's patient care services.

Almost every department in the corporation was involved in implementing the program, according to **Kevin Kihn**, RN, project manager for medical care management

"This has been a gigantic undertaking in terms of resource coordinating, trying to pull together the best of what we have with multiple enhancements and tie it together in an integrated system," says

Thomas Ruane, MD, medical director of preferred provider organizations and care management.

One of the biggest decisions was whether to develop a fully integrated program, to partner with an external company to develop the program, or to contract with a variety of entities for disease management, Ruane says.

The company decided to handle all the patient care components internally and to create the integrated program instead of hiring outside vendors for disease management.

"It didn't make sense for us to put a middle man in the system and have it chopped up with one or two diseases being handled by one vendor. We felt like we had the opportunity to have a more comprehensive program by handling it in-house than if the customer was going to a number of external vendors," Ruane says.

The insurer did establish a relationship with partner organizations for assistance in integrating the various parts of their care management program.

For instance, they hired Franklin Health International to further train the nurse-case managers to improve their operating efficiency. The organization already had a contract with Franklin Health for complex case management of the sickest part of the population.

"We learned that they had a particularly well organized system for delivering case management and subsequently contracted with them to train the nurses in our system," Ruane says.

They contracted with an outside vendor for a work management system to help coordinate all parts of the program, and another outside vendor to analyze member data and point to the biggest opportunities to make the biggest impact in disease management. Reports show gaps in care such as lack of screening tests or patients who have a combination of diagnoses but are not receiving recommended treatment.

The insurer uses the information to make proactive calls to members before their problems need intensive management.

"Our case management interventions are not limited to the disease management category. Other methodologies are used to identify other kinds of cases where there is an opportunity for intervention," Ruane says. ■

Depression guidelines help chronically ill

Behavioral issues can exacerbate conditions

Kaiser Permanente, one of the country's largest integrated health care organizations, has developed guidelines for incorporating depression management into its disease management programs.

The organization's Care Management Institute (CMI) is among the first organizations in the nation to earn disease management certification for depression from the National Committee for Quality Assurance (NCQA).

The organization also received disease management certification for its diabetes, asthma, and heart failure programs.

Kaiser developed its first depression management guidelines in 1999 to help improve care for patients who have a diagnosis of depression, according to **David Price**, MD, depression clinical lead at CMI.

"We know that in the primary care setting, anywhere from 20% to 60% of the patients who come into a primary care physician's office have a behavioral health issue, including depression," he reports. Patients who have chronic diseases such as heart disease, chronic pain, and diabetes along with major depression disorder do far worse as far as clinical outcomes are concerned than patients who do not have depression disorder, Price adds.

"Patients with major depressive disorder and other chronic medical conditions don't function as well, they utilize the health care system much more, and they don't get the same benefit from treatment as patients without major depression disorder, he says.

The Kaiser Care Management Institute's goal is to come up with dynamic models of care that can be used throughout the Kaiser system. Each region adapts the program to meet its own individual needs.

"We are here to be a resource to help our clinicians better understand the evidence in diagnosing, treating, and managing the care of people with depression," says **Maryam Firouzian**, MBA, depression project manager at the Kaiser Permanente's Care Management Institute, in Oakland, CA.

For instance, one region is considering integrating the depression disease management program into their diabetes disease management program. Another is screening congestive heart

failure patients for depression.

"We recognize that the resources could be used differently in different regions and are working with the regions to help them adapt them to their needs," Price says.

In addition to the guidelines, the CMI Depression Care Program includes tools that case managers can use to screen patients for depression as well as treatment recommendations for physicians and other clinicians.

When a care manager talks to patients, she asks them two questions: In the last four weeks, have you felt depressed? In the last four weeks, have you lost interest in activities you used to enjoy?

If the answer to either question is "yes," the care manager has a menu of seven screening instruments she can use to further screen and appropriately diagnose the patients for depression.

"We included tools we reviewed and found to have high accuracy. Because we recognize that different people may have their favorites, we included tools with similar accuracy in diagnosing and allow the care managers to pick out what they like," Price says.

When a care manager determines that a member may be suffering from depression, he or she alerts the primary care physician.

"What they do then depends on the local setting. If the care manager is in the same office with the physician, she may see him or her in person. If not, she will contact the primary care physician by telephone," Price says.

Generally, the next step is for the physician to make sure the diagnosis was correct. From there, the protocols vary based on the severity of the depression and the comorbid condition, Price says, adding that treatment often is a collaborative process between the patient care manager and the physician.

The CMI tracks outcomes annually and has preliminary data for the 2001 report period that supports the benefit of the depression screening and treatment, Firouzian says.

For instance, in the case of diabetics with depression disorder, those who received treatment spent fewer days in the hospital than those who were not treated, she adds.

"One of our goals is to specifically measure the accuracy of the diagnosis of major depression. We are hoping that the guidelines will help us diagnose depression more accurately," she says.

Evidence-based recommendations

Kaiser's depression guidelines are based on systematic reviews and analysis of clinical evidence in combination with the experience and knowledge of the health plan's depression experts where evidence is lacking, according to Price.

A group of clinicians from across the Kaiser regions met to develop the guidelines, including primary care physicians, psychiatrists, nurses, psychologists, pharmacists, and other behavioral health specialists.

The work group generated a list of about 90 questions it wanted to answer about the diagnosis of depression and its treatment in the primary case setting, then selected a list of about 30 questions to work on Price says.

"We performed a systematic literature review of all the studies that were relevant to each question. We assembled the articles, analyzed them, put them into evidence tables and, as a group, met to review the evidence," Price adds. The group developed a number of evidence-based recommendations for the treatment and diagnosis of depression.

"There were a number of questions where there was insufficient information available to label the recommendations as evidence-based. In these situations, we therefore developed a number of consensus-based recommendations," Price says.

The guidelines, recommendations, rationale, and analyses filled a large binder, which the committee reduced to a six-page trifold card with clinical algorithms to help clinicians recognize and treat major depression disorder.

The first depression guidelines were developed in 1999 and revised in 2001. They will be examined and updated by a committee of about 20 members this year, Firouzian says. ■

COMING IN FUTURE MONTHS

- What member satisfaction surveys can do for you
- Taking a team approach to patient care
- How to help high-risk patients comply with their treatment plan
- Coordinating care for terminally ill patients

CE questions

1. Case managers engaging in activities that are not in their scope of practice is one of the most prevalent ethical problems in case management, according to Mindy Owen, RN, CRN, CCM, chairwoman of the ethics committee and a member of the executive board of the Commission for Case Manager Certification.
A. True
B. False

2. In the first year of the Moms GEMS prenatal program at Trenton, NJ-based Horizon/Mercy, what percentage of members in the program had premature babies?
A. 1%
B. 5%
C. 13%
D. 19%

3. Which of the following are main components of BlueHealthConnection, an integrated care management program?
A. Guided self-management
B. Integrated case management and disease management programs
C. Complex case management services
D. All of the above

4. When were Kaiser Permanente's first depression guidelines developed?
A. 1995
B. 1997
C. 1999
D. 2001

Answers: 1. A; 2. B; 3. D; 4. C.

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™

Health insurance declining among workers

Health benefits are declining for Americans for the first time since 1993, according to the Employee Benefit Research Institute (EBRI).

The 2001 decline in the percentage of Americans receiving health insurance as an employment benefit is the start of a new trend, according to the November issue of EBRI reports (www.ebri.org).

Coverage cutbacks were caused by the rising cost of health benefits, particularly among small employers that have had to drop health benefits or require workers to pay for them, the report says.

About 62.6% of all Americans were covered by employment-based insurance benefits in 2001, down from 63.6% in 2000. At the same time, the number of uninsured Americans increased and the percentage of people covered by Medicaid increased while the Medicare population remained the same.

"As long as the economy remains weak and the cost of providing health benefits continues to rise, these trends should be expected to continue or worsen," says **Dallas Salisbury**, EBRI president and chief executive officer. ▼

Plan knowledge affects how consumers look at cost of drugs

Consumers' drug-buying behavior may be based on how much they know about their personal health care coverage, a Harris Interactive survey has revealed.

According to the survey, consumers with low levels of knowledge about their coverage appear to be less price-sensitive when they fill prescriptions while those who more thoroughly understand their health coverage are more concerned with price.

The survey showed that more than a third of consumers said they didn't know how their co-pays were structured.

Only 16% reported that they almost always or often ask their physicians whether the medications are covered by their insurance. Only 4% had changed their prescription plan because a specific drug was not covered.

When presented with the option of a cheaper drug, nearly 60% chose to stay with the more expensive drug. Of those consumers who chose the cheaper drug, 98% said they would change for a price difference of $10 or less. ▼

Physicians report frustration with managed care red tape

Sixty percent of physicians responding to a survey by the Pennsylvania Medical Society expressed frustration with eroding patient-doctor relationships and blame lack of time for the problem.

The survey of 330 physicians revealed that they spend an average of 12 minutes with each patient and 40% say they spend less time with their patients than when they first started practicing medicine.

Many of the physicians blame HMOs and managed care for the lack of time they have to spend with their patients. They cite economic

pressures caused by declining reimbursements as the reason more patient visits must be crammed into their office hours.

More than 80% of the physicians reported that they aren't fully reimbursed by insurance companies, leaving them with less revenue to attract and keep employees and buy the latest medical equipment.

"Having to generate more money due to decreased reimbursements by the insurance company is the primary cause of decreased patient time," wrote one physician who reported that one insurance company decreased reimbursement by 8% and his medical liability rates went up $100,000 a year.

Physicians also cited managed care red tape, such as increased documentation requirements, as a cause of decreased time they spent with patients.

Despite the frustrations, 67% of physicians surveyed said they would become doctors all over again. They cited the change to help people and gratifying relationships with patients ahead of money or prestige as the reason to become a physician. ▼

Mental health, musculoskeletal conditions, impact productivity

Musculoskeletal conditions, including arthritis, low back pain, repetitive motion strain, and mental health problems, mostly depression, have the biggest negative impact on worker productivity, according to a new survey by the Institute for Health and Productivity Management (IHPM), a nonprofit research organization with headquarters in Scottsdale, AZ.

The organization surveyed 34 employers with a total of 1.2 million employees.

The survey asked workers about the cause of absenteeism and the health and disease issues that diminished their performance at work. Pregnancy was the third-leading cause of absences from work.

Few of the employers surveyed offer disease management programs for muscular skeletal conditions or mental problems, the report showed.

"If more employers established disease management programs to deal with these health issues, they would be able to reduce their overall health-related costs while increasing productivity," says **Scott Sullivan**, president and CEO of IHPM. For more information on the IHPM, see their web site at www.ihpm.org. ▼

White Paper addresses HIPAA concerns, disease management

A comprehensive analysis of the Health Insurance Portability and Accountability (HIPAA) and its impact on disease management has concluded that the new privacy regulations will not hamper disease management programs, according to the Disease Management Association of America (DMAA).

The association's White Paper concluded that the U.S. Department of Health and Human Services has fully safeguarded the ability of legitimate disease management programs to use and disclose protected health information for activities within the DMAA's industry consensus of disease management.

"While a lot of things in HIPAA are still unclear, disease management is not one of them. The White Paper's legacy will be to eliminate any concern that disease management cannot coexist with strong patient privacy protections, that disease manager somehow hinder or is hindered by privacy. Neither is true, and this initiative finally proves it," says **Warren Todd**, DMAA's executive director. The document may be obtained free of charge from DMAA. See their web site at www.dmaa.org. ■

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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