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INSIDE

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What's in the future? More opportunities, fewer case managers

CMSA issues its 'top 10' list of case management trends

There's an increased demand for the services of case managers but, at the same time, a shortage of nurses, who typically move into the case management role.

These are among the trends identified by the board of directors of the Case Management Society of America (CMSA), based in Little Rock, AR.

CMSA polls its board of directors annually about trends in case management as part of the organization's focus on meeting the needs of practicing case managers in a changing health care environment.

The nursing shortage will have a big effect on case management, since the large majority of case managers are nurses. At the same time, there is an increasing demand for case managers.

"If you look back just five years ago, case managers worked primarily in workers compensation and in independent case management businesses," says **Karen Chambers**, RN, CCM, CDMS, president of CMSA. Now many health plans, physician offices, and other providers have case managers.

At the same time, the aging baby boomer population creates a growing demand for coordination of health care services, including a trend toward individuals hiring case managers to help patients navigate the health care system.

"Case managers have a lot of opportunities, but along with opportunity, there is an increase in demand," Chamber says.

Because the role of case managers is expanding at the same time the nation is facing a nursing shortage, some case management roles are being consolidated for efficiency's sake, creating frustrations and a heavy case load for case managers.

Chambers cautions that some businesses may be tempted to put people into the case management role without sufficient training, which could have a negative impact.

"The increased opportunities for case management and the shortage

of nurses raises the question as to whether we should look past nurses and social workers to find case managers. I think that is one trend we are going to have to watch and see," Chambers adds. Here is the list of trends in case management for the future:

1. Demonstrating and improving outcomes of case management

"All case managers have anecdotal stories about how wonderful we are, but there is no standard method for measuring outcome and impact. We need to be able to demonstrate our value and our worth in terms that a CEO can understand," Chambers says.

The Council for Case Management Accountability, led by **Sherry Aliotta**, RN, BSN, CCM, has undertaken a lengthy project to develop indicators that measure the effectiveness of case management.

An initial draft of measurements that case managers can use to show their effectiveness is scheduled to be available for public comment in time for the CMSA conference in June, Chambers says.

The Council has been working on three state-of-the-science papers: "Patient Adherence Outcome Indicators and Measurement in Case Management," released last year; "Involvement/Participation Empowerment and Knowledge Outcome Indicators of Case Management," released in late 2002; and "Coordinator of Care," scheduled for completion later this year.

2. Consumer-directed trends

The public's growing awareness of the case manager as a source of help with health care coordination and direct-to-consumer case management will create more demand, the board report says.

3. Chronic care management

These trends include disease management and population health management, elder care medical management, and the increasing need to spend more time with patients who require medicines but cannot afford them.

4. Education

There is an increasing demand for web-based case management education as well as in-house case management training to deal with the lack of experienced case managers.

The board of directors sees an increasing need for continuing education to maintain certification along with increasing difficulty in finding time and resources for case management education.

5. Case manager/physician relationship

Case managers can expect to work as a team with the physician and the patient in the future, the board predicts.

CMSA is convening a physician summit this month to improve effective collaboration between physicians and case managers in both payer and provider settings. Participants will represent multiple practice settings, payer/provider venues, and specialty disease states.

"I do believe that physicians are aware of case managers and based upon their personal experience have either a positive or negative impression. It is our hope that physicians can understand how to utilize our services and how to work with us for better patient care," Chambers says.

6. Increasing attention to cultural and linguistic competency

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Editorial Questions

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As our country becomes more multicultural, there will be an increased demand for culturally diverse case managers and for educational resources to support cultural competency, in addition to more demand for bilingual case managers, Chambers says.

"It is imperative that case managers understand the needs of patients and develop a plan of care with the provider, the patients, and their families. When case managers are working across cultural boundaries, it becomes even more important," she adds.

7. Legal and ethical issues grow in concern for case managers

There is a growing interest in legal and ethical issues relating to case management practice and how to understand the issues and avoid legal and ethical pitfalls.

8. Increasing CM legislation, rules, and regulations

Case managers need to be familiar with HIPAA, other federal regulations, and a growing body of state legislation, rules, and regulations governing case management.

9. Shifting case management roles and job functions

Among the items listed by the board under this category are use of case management software and other health care technology; increased need for certification and accreditation; an increase in case managers in emergency departments, home health, and skilled nursing facilities; decrease in use of critical pathways in favor of "evidence-based practice tools"; and consolidation of utilization review, discharge planning, and case management into one department.

10. Growing need for more case managers

The growing recognition of the services that case managers provide, the aging of baby boomers, and their need for medically complex care and chronic disease management are among the factors contributing to this trend. ■

Health plan launches stress management service

Program takes a proactive approach

When members call the Blue Shield of California Lifepath Advisers[sm] line, they can get answers to health and wellness questions from a registered nurse, speak to a mental health counselor, or consult with a specialist on everything from childcare to legal and financial questions.

The program, launched in July 2002, takes a proactive approach to dealing early on with problems that affect members' health.

"Clinical research shows that there are a large number of primary care visits for psychosocial problems and stress over life events. We decided that our members shouldn't have to wait until something is big enough to go the doctor's office. Instead, we want to help people as early as possible to find personalized solutions for their specific issues," says **Deborah Schwab**, MS, RN, director of new product development for the San Francisco-based health plan.

The seeds for the Lifepath Advisers program came as the result of market research during which members were asked what their biggest concerns were and how Blue Shield of California could help.

Their No. 1 request was for help with problems that took away from their job, such as finding resources to care for older adults and children, followed by access to nurses or counselors outside of regular business hours.

The members asked for support services in the event of the death of a loved one and social support when moving or leaving school.

The innovative evidence-based service, Lifepath Advisers, gives members access to registered nurses- and masters-level counselors 24 hours a day, seven days a week for consultation, assessment, and referrals on a wide range of services.

"We are encouraging members to access our care early on so we can catch problems before they become more complex," Schwab says.

The new program brought together a number of disjointed services, Schwab says. Members can call one telephone number and have the option of speaking with a nurse, a counselor, or a number of specialists who can help with child care, elder care, legal, and financial issues.

"What makes it powerful is that no matter which one they select as a starting point, they receive an assessment, a high-level action plan, and assistance with navigation. If they select the 'nurse' option but also feel a personal consultation with a counselor is advisable, they can be patched in on the spot," Schwab says.

The program was designed to limit system fragmentation and to decrease the potential for members falling through the cracks.

For instance, if a member talks with a counselor and realizes after a few telephone calls that he or she needs to tap into the mental health benefit, the member continues with the same counselor but merely transitions into the mental health benefit.

"Often, people don't know where to go to get into the health care system other than to go to the emergency room or the doctor's office. These services are a great place for them to start. They get an assessment and a plan of care so they know the wisest use of the system resources," Schwab says.

The benefit to members and employer groups is that they have only one relationship to manage. The price point is lower than if the employer contracted for the individual services because of the health plan's purchasing power, she adds.

The health plan built coordination among vendors into the system and created flags when members call in so whomever they talk to can refer them to other areas as well. For instance, if a member calls about a problem and mentions a chronic illness such as diabetes or asthma, the member is referred to the disease management program.

The nurse liaison who runs the program receives daily reports from vendors about the reason people are calling. She works with the Blue Shield of California in-house case managers and notifies them of any patterns in calls and of individual members who may need service from the case managers. ■

Service addresses a wide range of member concerns

Counselors provide assessment, plan of care

No matter which Lifepath Advisers[sm] service Blue Shield of California members choose, they get a comprehensive assessment and a plan of care to help them deal with their problems.

"We designed the program as an integrative service that can address the broad range of concerns people told us affects their health. We combined them with our health plan benefit and our mental health benefit and use the same network of providers to deliver the services," says **Deborah Schwab**, MS, RN, director of new product development for the San Francisco-based health plan.

Here are the three components of the system and how they work:

• **Nurse line.** Members who choose the nurse line option can receive self-care information and guidance along with advice to help them determine what setting is best to handle their health care problem, whether to take care of the problem at home or to make an appointment with their physician or go to the emergency department.

The nurses also offer lifestyle counseling, particularly involving nutrition and exercise, and offer coping tips for chronic conditions. Members can access more than 1,000 audiotapes that give a quick overview of medical conditions and various psychosocial topics.

The nurse line staff flag members who may need a follow-up and keep in touch by telephone.

• **Personal consultation service.** Counselors provide telephonic consultations for personal and emotional issues, including grief and loss and substance abuse. The counselors can offer up to three face-to-face visits if needed before the mental health benefit kicks in. The visits don't count toward the member's mental health maximum.

If the members' needs are more complex, they can transition smoothly to the mental health visit. The counselors give members a care plan and a preliminary assessment worked out in advance. As a result, the members are able to make the best use of their mental health benefits, Schwab adds.

"I've never met a patient who says 'today is the start of my mental health problem.' It's usually something that has been building for a long time. We want to catch the problem before it builds into a full-blown mental health problem that is more costly to treat," she adds.

• **Work-life resources.** This component puts members in touch with specialists in adult care, elder care, child care and family services, educational resources, financial consultations, and legal referrals. The initial telephonic consultation is free. After that, members receive a discount on the consultations. ■

Providing 'personal touch' increases satisfaction

Plan's CMs provide outreach in a variety of ways

The personal touch pays off for a health plan, **Terri Cox Glassen**, RN, MN, asserts.

As assistant vice president for consumer satisfaction at CIGNA HealthCare, Cox Glassen is in a

position to know.

CIGNA HealthCare, with headquarters in Bloomfield, CT, employs about 3,000 nurses in a variety of roles, many of them in programs that provide outreach to the members.

"Nurses are advocates by nature, and in managed care there is a lot of opportunity for nurses to play the advocacy role by helping members navigate the health care system," Cox Glassen says.

The nurses do everything from patient education to working with members in disease management programs to helping facilitate care through the continuum.

"People love it when nurses call them. In addition to improving member satisfaction, we find that the personal touch does help with health outcomes. For instance, we have a high rate of success in our disease management program, along with a high member satisfaction rating," Cox Glassen says.

Personalized support

The personal touch pays off in other ways for the health plan, she adds.

For instance, one member received a call while considering an open enrollment option. She was so impressed by the personal call, she decided to stick with CIGNA and told the case manager she was recommending the plan to her friends.

"This is another example of how the personal touch has made a difference," Cox Glassen says.

Among the health plan's outreach services are a 24-hour help line, staffed by nurses, disease management services, and on-site case management in some hospitals.

CIGNA HealthCare's disease management programs were initiated in 1998. Other nurse programs, such as the 24-hour help line, have been in existence for about five years. The company has had case managers for eight years.

"People don't have to be in the hospital or faced with a chronic decision to receive personalized support. Our member support is based on individual situations," Cox Glassen says.

The health plan's disease management programs are geared to patients with asthma, diabetes, low back pain, and cardiac disease.

"We focus on helping the healthy stay healthy and helping those with chronic illnesses have good quality of life," she says.

The disease management nurses contact the patients by telephone at intervals based on severity. It may be weekly for more severe patients or quarterly for patients who are doing well.

Each year, CIGNA looks at a variety of data including profiles of members, such as age ranges and specific clinical characteristics, drugs prescribed and filled, hospital admission rates, and tests ordered and conducted and their frequency.

The statistics help the insurer decide on the most appropriate disease management program.

The disease management programs have been highly successful for the plan, Cox Glassen adds. For example, the Well Aware diabetes management program showed a 26.6% improvement in nephropathy screening for potential kidney complications and an 11.2% improvement in eye examinations.

Among members who participated in the Well Aware diabetes program, hospital admission rates per 1,000 members dropped 20.8%, and inpatient day rate per 1,000 members declined 22.7%.

In a member satisfaction survey conducted by an outside firm, Well Aware participants gave a rating of 7.2 on a 10-point scale for having more control over their health than before they started the program. Those surveyed gave an overall satisfaction rating of 3.9 on a scale of one to five.

Cox Glassen has found that members are more likely to participate in disease management and other programs if they are proactively enrolled and given the opportunity to opt out rather than just offering the service as an option.

"People are busy and get bombarded by multiple services. It's better to reach out to members rather than waiting for them to come to you. The key to success in getting people involved in their own health is the personal touch," she says.

Nurse case managers from CIGNA HealthCare work on site in some hospitals, visiting the patients and making sure they have the appropriate education to go home safely, helping with discharge planning, answering financial questions, and giving support to members and their families.

"The nurses are assigned to hospitals based on geographical location and different situations with the hospitals. Their job is focused on helping patients in the hospital with whatever they need," Cox Glassen says.

A 24-hour telephone service, which is staffed by nurses with a clinical background, provides feedback to members with health care questions. In addition to answering general health and wellness questions the nurses help people who are having symptoms of diseases choose the most

appropriate level of care. For instance, they help people with chest pain decide whether it is indigestion or could be something more serious. If a parent calls in the middle of the night with a sick child, the nurses help them decide if they should take the child to an urgent care center or wait until morning to see the pediatrician.

"They are here to give the members peace of mind," Cox Glassen says. ■

Listen to members through satisfaction surveys

Plan makes changes to better serve its customers

Member satisfaction surveys give health plans a chance to hear the voice of the customer, says **Terri Cox Glassen**, RN, MN, assistant vice president of consumer satisfaction for CIGNA HealthCare with headquarters in Bloomfield, CT.

The health plan monitors member satisfaction on several levels. A national survey is done annually to measure member perception.

"We look at operational matters such as how we managed complaints and appeals, as well as general questions about how the members feel," Cox Glassen says.

When it comes to improving quality, whether it's clinical or service, the company's policy is to hear from every stakeholder, she says.

After the survey results are in, the health plan targets areas of improvement and comes up with ways to improve services. For instance, in 2000, 28% of customers surveyed reported problems related to inappropriate billing. The next year, after a series of initiatives, the figure was down to 14%.

Members who have had any kind of experience with CIGNA HealthCare received a short mailed survey with questions about the referral process, experiences with the network, and opinions about the number of physicians in the plan in their area.

Throughout the year, the company conducts specific member satisfaction surveys for participants in its disease management programs.

The members who participate increasingly are more satisfied the longer they stay in the program, Cox Glassen adds.

"Each year, the programs are evaluated, and we consider feedback from our customers in making changes such as revising the materials that are sent back. Our disease management staff uses the feedback to restructure the programs, and they get better as they go along," she says. ■

Pink-ribbon campaign helps remind members

During October 2002, case managers from CIGNA HealthCare made hundreds of calls to female members reminding them to get a mammogram and educating them about breast cancer risks.

As a result of these and other efforts, CIGNA has one of the nation's highest rates of mammography screening.

In preparation for the telephone calls during Breast Cancer Awareness Month, the case managers queried the health plan's databases to find out which members had not gotten a mammogram.

Those who were identified by the query received an outreach call from a nurse who asked if they had gotten a mammogram and encouraged them to do so.

The nurse case managers found that the members were pleased to get a call from CIGNA, and many had questions that the nurses could answer.

"We already had very successful rates for mammography and they increased as a result of this outreach," says **Terri Cox Glassen**, RN, MN, assistant vice president of consumer satisfaction for CIGNA HealthCare with headquarters in Bloomfield, CT. ■

Plan monitors meds to identify treatment gaps

Data go hand-in-hand with disease management

Pharmacy data are an integral part of case management of chronically ill patients covered under Horizon/Mercy, with headquarters in Trenton, NJ.

The case managers monitor pharmacy data to find out if members have been prescribed the proper medicine for their conditions and to make sure the prescriptions are filled and refilled on a regular basis.

"Pharmacy data are essential to disease management success. It's a real barometer for compliance and noncompliance," says **Pamela Persichilli**, RNC, director of clinical operations for Horizon / Mercy.

Horizon / Mercy covers more than 273,000 members, representing about 42% of New Jersey's total managed care market for the publicly insured.

In addition to a number of programs for pregnant women and children, the plan currently has disease case management programs for congestive heart failure, diabetes, asthma, and sickle cell disease.

The case managers in the health plan's disease management programs work with the pharmacy team to monitor whether patients have filled their medication prescription.

They can log into the pharmacy database, enter the ICD-9 codes for a particular disease state, and receive a list of members with the diagnosis and a profile of their medication, including who ordered it and when the prescriptions were filled.

They also check the pharmacy list against the list of members who have been identified through hospitalization and emergency department visits to make sure that no one falls through the cracks.

A case manager may run a pharmacy profile and realize the member is not on a diuretic or isn't taking cardiac medicine. In these cases, they coordinate with the primary care physicians and educate them.

If they find high-risk patients who have not had their prescription filled, they call the physician and educate the physician if necessary.

For instance, if the pharmacy profile shows that someone with congestive heart failure isn't on a diuretic or isn't taking cardiac medicine, the case managers make sure the physician has prescribed them. They make sure that all members in their diabetes management program are getting their prescriptions for ACE inhibitors filled.

"It means either they aren't taking it every day or they just haven't gotten around to getting it prescribed and don't realize the problem with missing a day or two," says **Giavanna Ernandes**, RN, MSN, APNC, Horizon / Mercy's team leader for disease management.

Most of the time if the case manager calls the member about a prescription, the member says he or she hasn't gotten around to having it filled, she adds.

The case managers can log onto the pharmacy system and look at the member profiles as often as they need to. They follow up to make sure the prescriptions have been filled regularly. ■

Program provides support to publicly insured with CHF

Target: Reduced hospitalization, better quality of life

In just six months of operation, the congestive heart failure disease management program at Horizon / Mercy has resulted in few hospital admissions for some patients.

"People who used to be in the hospital every other week have had longer lapses of inpatient services," says **Giavanna Ernandes**, RN, MSN, APNC, Horizon / Mercy's team leader for disease management.

The congestive heart failure program was begun last summer after the insurer looked at high utilization disease among its membership. Congestive heart failure (CHF) was one of Horizon / Mercy's most expensive diseases to manage.

"We had a longitudinal case management program, but it had very strict guidelines based on ICD-9 codes and limited resources to manage the program," Ernandes says.

The patients with the highest utilizations, hospital admissions, and medication costs were targeted first.

As of December 1,142 members had enrolled in the program. Until the weather got cold, the plan was identifying 15 to 20 members a month. In December, 50 members were enrolled in the program.

Ernandes expects the number to increase during the winter months.

"In the winter months, people with [CHF] tend to get sick and end up being admitted to the hospital," she says.

When a member is identified for the program, the case managers make outreach calls to these patients to find out about their disease, their understanding of the disease, signs and symptoms they are experiencing, and if they are being followed by the cardiologist or pulmonologist.

"The case managers look at the whole picture. We don't just call the member. That's vital, but we also provide other kinds of support," Ernandes says.

They set up appointments with a pulmonologist and a cardiologist if necessary and interact

with the member's primary care physician. If they feel the member will benefit, the case managers set up a nursing visit. They send a pillbox that helps the members comply with their medication regime and a scale if the member needs it.

They call them regularly to remind them to take their medication appropriately and check their weight daily.

"With severe patients, the key is education. Once you get them out of the crisis, the disease is very manageable as long as they know the warning signs — weight gains and shortness of breath," Ernandes says.

In addition to using claims data from hospitals and emergency room visits, the case managers mine pharmacy data for ICD-9 codes to identify CHF patients who might not have been hospitalized or visited the emergency room.

"We make sure that our case managers reach all of the members with congestive heart failure," she says.

Once a member is receiving case management, the plan has an automated system for documentation and follow-up.

"The case managers develop relationships with the clients and get to know them. Nothing is written in stone. Some may call more frequently if the member seems to need support," Ernandes says.

Any member who has had one or more admissions in the past six months receives a follow-up at least monthly for six months. If there are admissions during that period, the follow up continues for another six months.

Members who have had one admission in the last year get a follow-up call and receive a follow-up every three months.

During those calls, the case managers remind the members to take their medication, find out if they need transportation to their checkup, give them a number they can call for advice, and follow up on their treatment.

Over the winter months, the case managers remind members with CHF to get flu and pneumonia shots.

"We do a lot of education. Congestive heart failure can be managed and members can live a fairly healthy life if they follow the regime," Ernandes says. ■

Variations in treatment cause waste, inefficiency

Plan takes twofold approach to consistency in care

Everyone knows that inconsistencies in health care can adversely affect patient outcomes, waste time and resources, and ultimately cost the consumer, the provider, and the health plan money.

The staff at Highmark Blue Cross Blue Shield in Pittsburgh is working to do something about it.

"Health plans have extensive patient data and a lot of opportunities to improve care and lessen the degree of variation in practice patterns that affect health care quality, waste, and cost inefficiency," says **Don Fischer**, MD, MBA, a medical director for the insurer.

Variations in care are caused by physicians' lack of knowledge of the latest treatment techniques, lack of information that effective care was delivered, lack of an internal system to assure that the care was delivered, and failure of patients to follow the prescribed plan of care, he says.

"The health plan's role can be valuable in achieving the goal of reducing unwarranted variation and providing the best value for the health care dollar. Cooperation among all the stakeholders is necessary if we are going to be successful in giving the patient the best care and an opportunity to achieve the best outcomes," he adds.

Under Fischer's leadership, Highmark has launched a twofold approach to eliminating practice variations and improving the quality of care for its members — one dealing with members and the other with physicians. **(For details on the two programs, see related articles on pp. 21 and 22.)**

Highmark's integrated condition management program (formerly known as disease management) uses health coaches who work with patients to reinforce physicians' messages with the highest risk patients, to motivate them to comply with their plan of care, and to help them understand their condition.

The SMART Registry provides physicians feedback on their patients, their conditions, and compliance with effective care options such as recommended tests and medications, and practice-level reports that compare physicians to their peers in terms of quality indicators.

"They're not report cards. It's what we can do to help with process improvement. In the long run, we have found that this is the best way to save money," Fischer says.

The vast majority of physicians wants to do the right thing and know the right thing to do but don't have processes in place to see that it is done in a consistent manner, he says.

Highmark's aim was to develop programs that recognized the physician-patient relationship as critical in treating people with chronic diseases and to recognize that many patients have multiple comorbidities.

"We didn't want just a cookie-cutter program for patients," Fischer says.

Employers who are concerned about increasing health insurance costs are helping drive the focus on eliminating variations, Fischer says.

"In the employer world, unwarranted variation suggests a process out of control, the implications that quality is not optimal, and that dollars are being wasted," he says.

Fischer has long been interested in eliminating unwarranted variations in practice patterns. He joined Highmark in mid-2001 after practicing at Children's Hospital in Pittsburgh, part of an academic medical center. "I made the leap to come to a health plan because it gave me an opportunity to affect a much broader range of patients," Fischer says.

Fischer outlines three types of variation in care:

- **Effective guidelines variation**. This occurs when there is scientific evidence that a certain procedure should be done for a certain condition and it's not being done or being underutilized. An example is dilated retinal eye examination for diabetics.

The SMART Registry is Highmark's attempt to address this variation.

- **Preference-sensitive care**. This occurs when a patient has multiple options that may have equal validity. For instance, in the case of prostate cancer, patients may consider radical surgery, radiation treatment, or watchful waiting.

The health plan's health coaches give the patients unbiased information about all the options so they can choose what suits them best.

"It moves from the paternalistic system where the physician made all the decisions, and many times, the decisions were based on where the doctor trained and who trained them," Fischer says.

- **Supply-sensitive variations**. This is based on what resources are in the community. For instance, a city with more cardiologists may have more cardiac procedures being done. If there are more intensive care unit beds in a community, patient are more likely to spend the last part of their life in the ICU. ■

Data help physicians track patients, compliance

Provide ideas for better patient care

To get, on their own, the information that Pittsburgh-based Highmark Blue Cross Blue Shield's SMART Registry provides them, physicians would have to conduct extensive and time-consuming chart reviews.

The reports provided by the Pittsburgh-based health plan give physicians feedback on the entire population and on specific patients with chronic conditions. They point out opportunities for better patient care, such as showing evidence from the claims that evidence-based practice guidelines for a specific chronic disease are not being met.

"We want to ensure that the physicians treat and test patients on a regular basis according to evidence-based practice guidelines," says **Don Fischer**, MD, MBA, a medical director for the insurer.

The registry has been refined on a regular basis since it was rolled out in spring 2002 for some practices in one plan. The entire network was included in July.

It includes five chronic conditions: asthma, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, and diabetes, along with hypertension, which represents a significant comorbidity for most patients in the disease management programs.

A spreadsheet shows whether 13 quality indicators have been met for each patient. Patient information includes date of birth, age, gender, chronic diseases, and number of primary care visits during the past year.

The quality indicator data are color-coded. A claim for a quality indicator is green. Yellow means there is an opportunity to improve care.

"The physicians can look down the columns and easily see if there is one indicator they aren't doing consistently well," Fischer says.

For instance, one significant problem among Highmark patients is the failure of diabetics to get eye examinations.

"Many patients don't understand what needs to be done. They may not understand that it's a medical benefit, rather than a vision benefit, and they may go to the wrong physician and get the wrong test," Fischer says.

The health plan is educating the physicians about the dilated retinal eye examination, and

working with employers to promote the exam among their health plan members. ■

Integrated DM program supports recommendations

Highmark Blue Cross Blue Shield combined its previously disjointed disease management programs into an integrated condition management program that focuses on reducing the variations in effective care for five common conditions.

The health plan uses its "health coaches" for condition management, shared decision making, and for general health information and support.

The health coaches are registered nurses, dietitians, and physical therapists. They give patients information about their condition and help them make good health care decisions.

Patients who are eligible for the integrated condition management are identified through claims data, including pharmacy and standard medical-surgical claims. They are stratified based on the plan's prediction of utilization and cost.

The outreach is targeted to the severity level. Some patients get a mailing on their condition. Other may get active health coaching on a one-to-one basis from a case manager who is a nurse, a diabetic educator, or a therapist.

Most of the health coaches are registered nurses with a lot of experience and the ability to provide information that is customized to the needs of the patients, says **Don Fischer**, MD, MBA, a medical director for the Pittsburgh-based insurer.

"The health coaches help them understand why the physician has prescribed a certain regime and give them reinforcement and information so they can comply," Fischer says.

The health coaches also help educate patients who may be trying to decide among treatment options. "If you give patients unbiased information about the pros and cons of choices with equally valid scientific evidence, they will typically choose the most conservative option and be happier and more compliant," Fischer says. ■

Case managers advocate rather than spy

Know when to remove yourself from sensitive cases

By **Susan Gilpin**, JD
Mindy Owen, RN, CRRN, CCM
Commission for Case Manager Certification
Rolling Meadows, IL

Some insurance companies often use surveillance techniques in an attempt to discover fraud in workers' compensation and disability cases. When cameras are brought in, case managers should step out in order to avoid ethical dilemmas. But clearly this is easier said than done.

The *Code of Professional Conduct,* developed by the Commission for Case Manager Certification (CCMC) in Rolling Meadows, IL, describes the case manager / client relationship as a fiduciary relationship. In other words, clients are vulnerable and trust that the case manager will promote their best interests. Case managers are advocates for patients. The bottom line is that case managers must constantly base decisions on their patient's benefit and how that benefit can be obtained within the system.

• **Ethics case study:** A workers' compensation case manager is asked by a payer to review a surveillance tape and report her impressions of the client under surveillance. The case manager is a paid employee of the payer. How can the case manager fulfill a fiduciary obligation to the client without jeopardizing her job?

• **Discussion:** There are several key steps case managers should take in weighing any professional ethical dilemma:

— identification of issues;
— assessment of components;
— decision making;
— implantation;
— evaluation.

The life of a case manager is extremely difficult due to the multiple and often competing obligations, which pit the case manager's client against his or her employer. Case managers must comply

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with all applicable laws and codes of ethics, which come into play in each situation. Some of the issues the case manager in this case must confront are:

- the case manager's fiduciary responsibility to the individual receiving services;
- the case manager's obligation to his or her employer / payer;
- confidentiality issues raised by the Health Insurance Portability Accountability Act, her state practice act, her professional standards of practice, and her professional code of ethics.

In most cases, one of the case manager's best defenses against ethical and legal dilemmas is to fully inform the patient client up front about his or her options, the coverage of the plan, choices for going outside the plan and, in workers' comp cases especially, the relationship between the case manager and the payer as well as clear identification of all the parties to whom the case manager must report findings.

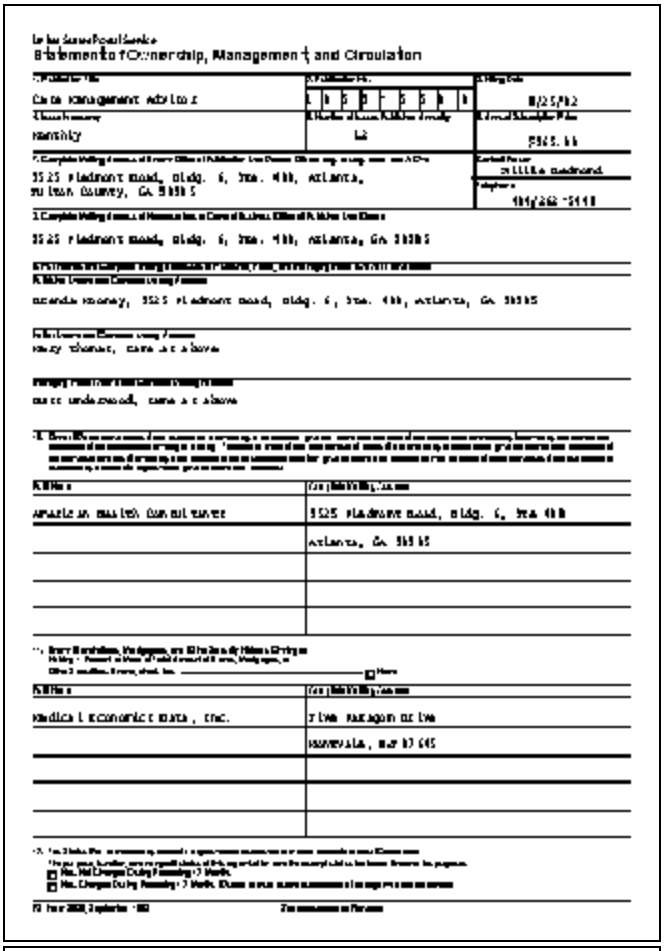
Making an ethical decision is easier if case managers establish a clear understanding at the very onset of the client's wishes and needs and the case manager's role and responsibilities. It is absolutely critical that case managers represent themselves honestly. The case manager must always make it clear to their clients, verbally and in writing, what the case manager can and cannot do.

This includes fully informing clients if the people who provide their benefits employ you. If the client seems to have a limited understanding of what that means, repeat yourself often. It also is good to document this information in writing so that the client has a copy for his or her records as well.

Ethical decision making also is easier if the case manager's job description accurately reflects the principles outlined in the CCMC *Code of Professional Conduct*. In a perfect world, the case manager's employer would have standards, which also contain these principles, so that the case manager is not placed in the position of having to jeopardize his or her employment in order to do what is right for a client.

If you have not recently reviewed your job description, pull it out and read it critically. Does it list activities in which you will not participate due to conflict of interest with applicable laws or your professional standards of practice or code of ethics?

Surveillance is a common practice in the workers' compensation arena, but it places the case manager in very muddy waters. In a best-case scenario, a case manager could remove him- or herself from any case in which surveillance occurs on ethical grounds and remain employed.



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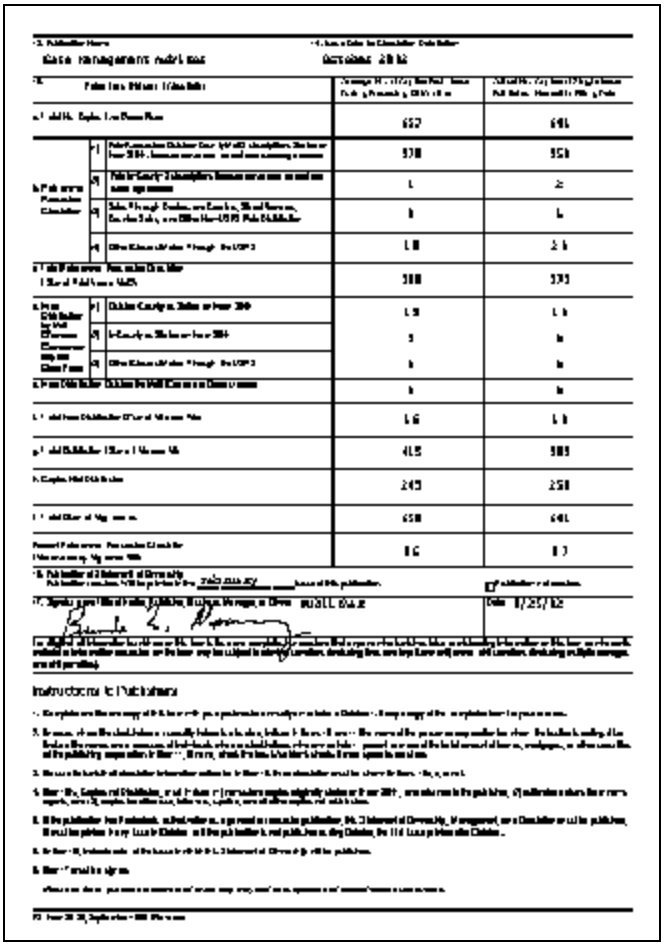

Case management advisor

October 2002

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Instructions to Publishers

CE questions

5. Which of the following was not identified as a trend in case management by the board of directors of the Case Management Society of America?
A. Growing need for more case managers
B. Increased use of clinical pathways
C. Shifting case management roles and job functions
D. Chronic care management

6. Which of the following is a component of Blue Shield of California's Lifepath Advisers service?
A. Nurse line
B. Personal consultation service
C. Work-life resources
D. All of the above

7. What year were CIGNA HealthCare's disease management programs initiated?
A. 1998
B. 1999
C. 2000
D. 2001

8. Identify two of the five chronic conditions included in Highmark Blue Cross Blue Shield's SMART Registry.
A. Diabetes and multiple sclerosis
B. Depression and coronary artery disease
C. Asthma and congestive heart failure
D. Multiple sclerosis and depression

Answers: 5. B; 6. D; 7. A; 8. C

While surveillance may be common practice for other professions, it is not usually part of the role of a case manager. However, as with any piece of information that you may process in order to deliver services to an individual, it is important that you are objective in your assessment and reporting.

Make sure that any documentation you create after reviewing a surveillance tape clearly reflects just what was portrayed on the tape and does not include any subjective conclusions. In addition, you must be clear in your written report to document the limits of your expertise and never go beyond those limits in an effort to curry favor with the employer/payer. And, as always, avoid stating your own opinion. ■

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™

CCMC seeks new commissioners

The Commission on Case Manager Certification (CCMC) in Rolling Meadows, IL, is opening nominations to fill four commission seats. Commission candidates are self-nominated. The deadline for submitting nominations is March 15.

The primary role of the CCMC is to establish eligibility criteria and examination content for the case management certification process and set policies and guidelines for the administration of the process.

Commissioners evaluate changes to the certified case manager examination and make sure they reflect current case management practice, serve as representatives of the commission, and develop policies to govern the implementation of CCMC's certification process. They act as a liaison between the CCMC and allied professionals, patients, and the public. Commissioners serve a four-year term and are appointed to at least one committee.

The CCMC is seeking candidates from a variety of settings who are active in their local and regional case management organizations.

For an application, e-mail the commission at commissioner@ccmccertification.org or call **Cheryl Gross** at (847) 818-0292, ext. 120. ▼

Hostility to managed care declining, poll says

While Americans still are unhappy on the whole with managed care, hostility and criticism have declined from their peak in 2000, a new poll by Harris Interactive has found.

The percentage of those polled who believe the trend toward managed care is a "bad thing" has declined from 52% in 2000 to 36% in 2002. Those who think it's a good thing remained constant at 36%.

The percentage of those who believe that managed care "will harm the quality of medical care" has declined from 59% in 2000 to 51% in 2002, but the pollsters concluded that the change is not because people think managed care will improve quality. Instead, it is because there has been an increase in those who don't think it makes a different or who are unsure, the researchers concluded.

The "modest trend" probably is due to a decline in physician hostility to managed care at a time when reductions in Medicare fees are their top issue, says **Humphrey Taylor**, chairman of The Harris Poll, Harris Interactive. As a result, there are fewer stories in the media that "demonize" managed care, he adds.

"It may also have been helped by current concerns about prescription drug prices and, more recently, increased hospital fees," he says.

The full results are available in issue 20 of *Health Care News* at www.harrisinteractive.com/news/newsletters_healthcare.asp. ▼

URAC handbook explains HIPAA security rules

The lack of a final HIPAA security regulation means that your organization doesn't have to provide security for your patient data, right? Wrong, according to a new handbook published by URAC. Your organization already has to protect

patient data under the Health Insurance Portability and Accountability Act (HIPAA) privacy rule, the book points out.

HIPAA Handbook: What Your Organization Should Know About the Federal Security Rule is the third in a trilogy of books published by URAC focusing on HIPAA.

The book was issued to help the health care industry cope with the uncertainty surrounding the HIPAA data security regulation. It includes explanations and strategies by the national's leading experts for meeting security requirements under HIPAA.

"The health care industry has been waiting for years for the final HIPAA security standard to be published. Nevertheless, regulators of all stripes believe that data security is good business practice and health care entities should not wait for the regulation," says **Dennis Melamed**, lead editor and author of the handbook.

The most recent publication is $65 and is available through the URAC web site at www.urac.org. The trilogy of HIPAA books is $175. ▼

Dietary counseling advised for at-risk adults

Dietary counseling can be beneficial for adults with high cholesterol and other risk factors for diet-related chronic disease such as high blood pressure and obesity, the U.S. Preventive Services Task Force has recommended.

The Task Force found that effective counseling for promoting healthy diets among patients at risk for cardiovascular disease requires multiple group sessions or individual behavioral counseling by specially trained physicians, nurse practitioners, nutritionists, or health educators.

The Task Force is an independent panel of experts sponsored by the Agency for Healthcare Research and Quality (AHRQ).

In 2002, Medicare began covering nutrition therapy for beneficiaries for diabetes and kidney disease. Studies suggest that people who eat diets low in fat, saturated fat, trans-fatty acids, and cholesterol and high in fruit, vegetables, and whole-grain products have lower rates of death from coronary artery disease, heart disease, and possibly several forms of cancer.

The task force suggested a team-based approach to nutritional counseling. Strategies include multigroup or individual treatments and brief behavioral counseling supplemented by self-help materials, telephone counseling, and individually tailored health mailings and messages.

Recommendations are available at www.ahrq.gov/clinic/3rduspstf/diet. ▼

Americans wary of technology's impact on health care

Despite embracing technology in many aspects of their everyday lives, people are conflicted about the impact of information technology on their health care, according to a new survey.

While 59% of those surveyed agreed that information technology will give them a sense of empowerment in managing their health, a majority (53%) believe that new information technology will end up being more trouble than doing things the old way.

More than 60% believe that information technology will help them avoid unnecessary visits to the doctor but 77% believe that physicians will miss subtle clues in on-line interactions that they would pick up during a face-to-face encounter, according to the survey by First Health Group Corp.

At the same time, 61% believe that technology will raise the cost of health care, and 89% believe that patients will end up paying the additional costs.

A majority of those surveyed identified two types of information technology that could potentially improve their health care: Internet-enabled remote monitoring and personalized health management through e-mail or telephone reminders. For more information, visit the First Health web site at www.firsthealth.com. ■

Send 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.

Send items for publication to Mary Booth Thomas, Editor, *Case Management Advisor*, P.O. Box 740056, Atlanta, GA 30374. Phone: (770) 934-1440. E-mail: marybootht@aol.com.

CMA must receive news about conferences and seminars at least 12 weeks prior to the event to meet our publication deadlines. ■