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Proactive case management pays off for insurer in outcomes, cost savings

Program achieves a minimum 4.5-to-1 return on investment

The pilot project for Anthem Blue Cross and Blue Shield's proactive case management program was so successful that the insurer has expanded it to include 16,000 members who will receive intensive, personalized interventions to help them manage their chronic diseases.

The pilot program started with an intervention group of 1,200 members who were the beneficiaries of the new proactive approach to case management and a control group, subject to Anthem's traditional case manager services, such as authorization of treatment, coordination of care, and discharge planning.

"We focused on authorizing coverage and services, but there was nobody there to really look at the bigger picture," says **Alena M. Baquet-Simpson**, MD, medical director, state of Ohio, Anthem Club Cross and Blue Shield Midwest.

Members in the intervention group went through a thorough assessment, worked with their case managers, or care counselors as Anthem calls them, to set goals and to come up with ways to meet them. Their care coordinators call them at regular intervals to check on their progress and answer questions.

In the first nine months of the pilot program, members receiving the proactive case management interventions had 11% lower inpatient admission rates than the control group, plus their inpatient costs were 10% lower. Total cost of care for the intervention group was 13% lower than those of the control group.

When the actuaries looked at expenses vs. cost savings, they calculated that the project had between a 4.5-to-1 and a 5.2-to-1 return on investment.

"One of our goals in the pilot study was to determine the value of the proactive approach to members. We put a lot of effort into designing the program so the results would be valid. Our actuaries evaluated the outcomes and put them to the most stringent level of analysis," Baquet-Simpson says.

Clinical outcomes, based on member self-reported data before and after the program began, included:

- 13% fewer members were smoking.
- 19% more were following low-fat or low-cholesterol diets.
- 16% more were participating in a regular exercise program.

Among members in the program with coronary artery disease, an additional 13% were able to reduce their cholesterol level to below 200.

Among members with congestive heart failure, there was a 33% increase in people weighing themselves daily.

Diabetics improved in five critical areas: receiving dilated retinal exams, foot exams, cholesterol screening, hemoglobin A_{1C} testing, and glucose control testing. In a member satisfaction survey, 97% of members rated their overall satisfaction with the program as good, very good, or excellent.

When asked how satisfied they were with the support and tools provided by Anthem Blue Cross and Blue Shield to help them manage their own health, 98% were satisfied.

"We found out it is possible to achieve a win-win situation. Our members are winning because of improved health. The physicians are winning because we are promoting better adherence, and the health plan wins because of enhanced member satisfaction and optimized resource consumption," Baquet-Simpson says.

The program is geared toward chronically ill people who are likely to need health care services.

"The care counselor program is more proactive, member-centric, and collaborative than the traditional case management program. It's all about empowering members to make health changes. The care counselor works in a supportive role, helping the members identify what motivates them toward making healthy changes that will reduce the need for services in the future," says **Mary Beth Newman**, RN, CMAC, A-CCC, senior project manager — case management at Anthem BCBS Midwest in Mason, OH.

Members are encouraged to call the care counselors with questions or if they have information they want to share.

Physician responsive has been positive.

"We let the physicians know that we are here to help them and to support adherence to their treatment plan," Newman says.

The care counselors are licensed health care professionals with significant clinical experience. Anthem Blue Cross and Blue Shield provided training in case management, chronic diseases, and in how to determine a member's willingness to change.

The care counselors work with members who have been identified as having the potential for high resource utilization. They determine what the members' needs are, help them set goals, and facilitate addressing their needs and goals.

"The key functions are defined by case management standards of practice. They are assessors, planners, facilitators, and advocates," Newman says.

Identifying the member's personal goals and developing a case management plan to support them is a key to the program, she adds.

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Editorial Questions

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

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For example, the client of one care counselor had diabetes, coronary artery disease, and hypertension and weighed 350 pounds. Every clinician the man had come in contact with had told him to lose weight, but that wasn't his goal.

Once the care counselor established a rapport with the member, she found out that he didn't like taking so many medications and wanted to get off some of them.

"As a natural fallout, he realized by himself that losing weight was the way to cut down on the medications he had to take," Newman says.

As a result, the man lost 50 pounds.

"After he lost the weight, he was able to get off his diabetes medicine and avoid the side effects it caused. His blood sugars and hemoglobin A_{1C} are normal now. He lost the weight because the care counselor worked with him to meet his personal goal rather than setting her own goal for him," Newman says.

The underlying focus of the program is for the care counselor to work with members to educate and empower them to manage their own health, Baquet-Simpson says.

The members are more likely to meet personal goals than those set by the care counselor, she adds.

"The care counselors share educational materials with members. The educational materials and clinical focus are all on evidence-based care. Focusing on methods that have been proven to enhance health are very important when it comes to making sure the results are what you are looking for," Baquet-Simpson says.

Care counselors are assigned by geographic areas to ensure that they are familiar with the community and what resources are available for members.

"It's a big asset when it comes to helping members navigate the system and coordinating needs with benefits and resources," she says.

The care counselors typically manage the care for about 150 members, depending on the severity of their illness and the care they will need.

The care counselors' assessments categorize the members into risk levels, each with a minimum number of interventions.

"We set a minimum number as a safety net so no one will fall through the cracks. The low-risk members are contacted at least quarterly," Baquet-Simpson says.

The care counselors can graduate members from the program based on their progress or lack of it.

"When we went into it, we didn't have an endpoint. We learned that there are some people who meet their goals and others who reach a plateau as far as their readiness to change," she adds.

The biggest reason that members are graduated from the program is that they have met their goals.

"The care counselors are engaged in regular monitoring and evaluations and know when the goals have been met," Baquet-Simpson reports.

The care counselors graduate some members when they reach a plateau or haven't made any progress despite interventions.

"The care counselors continuously assess readiness to change, and if they don't see that the member is moving toward change, they think about graduating them from the program," Baquet-Simpson says.

If a member starts to show high-risk characteristics again after graduating from the program, the predictive model identifies them, their care counselor is alerted, and the member is re-enrolled. ■

Plan fine-tunes its CM via pilot program

Staffing changes, comorbidities are focus

When the leadership team at Anthem Blue Cross and Blue Shield discussed its future medical management strategy in 2001, the team considered that proactive case management would be a major component.

At the time, there were little data to demonstrate that intensive case management added value, says **Alena M. Baquet-Simpson**, MD, medical director, state of Ohio, Anthem Club Cross and Blue Shield Midwest.

"We wanted to develop a program to decide what would work for our organization in terms of case management goals and the daily work of case managers. We structured a pilot program so we could have valid outcomes to demonstrate the impact of the interventions," she says.

Anthem Blue Cross and Blue Shield provides health care benefits to more than 11.7 million people in nine states.

An examination of the cost data showed that 7% of the commercial population was responsible for 50% of the claims costs over a 12-month period. The goal of the pilot project was to create a win-win situation for the members and the

health plan through a proactive case management approach.

"We wanted to assist them in improving their own health and optimize resource consumption at the same time," Baquet-Simpson says.

The health plan developed a predictive model to identify members for both the control and the intervention group. The members had similar characteristics, such as chronic conditions and intervention patterns.

The control group received traditional case management interventions, such as approving coverage for treatment and discharge planning. The intervention group received intensive, proactive case management.

After studying the data for the first nine months of the pilot project, Baquet-Simpson and her team at Anthem Blue Cross and Blue Shield made changes in the proactive case management program, based on lessons they learned.

"The results of our pilot project were extremely positive and suggest that proactive case management can have a positive impact. Along the way, we have learned some valuable lessons that have allowed us to change our program to make it even more effective," says Baquet-Simpson.

She shares some of the lessons with *Case Management Advisor*:

• Take into account whether a member is ready to change.

"We've learned by experience how critical it is to take into account an individual's readiness to change," Baquet-Simpson reports.

The company brought in outside consultants to educate the care counselors on how to determine a member's willingness to change. The case managers earned continuing education credits for participating in the educational process, which included role-playing and videos along with didactic lessons.

"We realized along the way how critical it was to focus on readiness to change and confidence to change and to give the care counselors the tools to assess them. Part of the role of being an advocate is respecting the member, and you get to the point that you have to respect their feelings about changing," she adds.

• Focus on comorbidities.

In the beginning, Anthem's proactive case management program focused on eight chronic conditions that typically consume large amount of health care resources. They are: coronary artery disease, congestive heart failure, diabetes, hypertension, hyperlipidemia, stroke, chronic renal failure, and chronic obstructive pulmonary disease.

After a while, the team realized that other conditions, particularly obesity and depression, affected the health of the members in the program.

When Anthem evaluated one group of members, it found that 81% had issues relating to obesity management or overweight and that 43% had problems with depression.

"One big lesson we learned what that we needed to consider other comorbid conditions," Baquet-Simpson says.

The program now includes counseling for depression and obesity information along with the education on the members' chronic illnesses.

• Free up the RNs to focus on members' health behaviors.

The pilot project pointed up the importance of having someone besides the case managers handling clerical and administrative tasks, Baquet-Simpson says.

As part of the expansion program, the health plan has hired people who are not registered nurses to handle the enrollment process, calling the members to explain the program and setting up the first telephone appointment with the care counselor.

"Care counselors in the proactive case management program are able to spend more time intervening with members. We needed to free them up from clerical tasks to concentrate on direct member contact," she says.

• Develop a comprehensive medical management system.

The success of the program has allowed the insurance plan to update its medical management system to support the proactive case management program on a long-term and systemwide basis.

"We want to have as much of the process automated as possible to maximize the case managers' time. With the success of the program, we've gotten approval to do so," Baquet-Simpson adds. ■

New program helps breast cancer patients

Successful pilot becomes full-time program

A case management program for newly diagnosed breast cancer patients at MeritCare Health System in Fargo, ND, helps women smoothly navigate through the health care maze as they make treatment decisions.

The program started out as a pilot project in January 2002. The response from patients and staff has been so good the health system has made the job a full-time position.

"They have realized what it has done in the way of patient satisfaction and in helping to streamline the care," says **Linda Sveningson**, RN, MS, AOCN, breast cancer case manager at MeritCare.

At MeritCare, breast cancer case manager is one full-time equivalent position shared by two master's-prepared nurses.

The nurses have an active caseload of about 45 patients, 20 of whom are new patients and the rest of whom are going through surgical treatment.

In a typical month, Sveningson actively works with about 45 patients. About 20 are new patients who have just gotten a breast cancer diagnosis. The rest are those she is following through surgery.

"I'm the person they can call to point them along the way and give them any information they need," she says.

Sveningson is based in the radiology portion of the breast clinic, where many patients get the first information about their diagnosis. She calls patients within a few minutes after the radiologist calls to tell them their breast biopsy is positive.

"I am there to provide support and education and to coordinate the appointments they will need," Sveningson says.

"These patients are in an absolute state of shock. On the first day, I answer their most urgent questions and call them again the next day to talk further. The next day, they want to know what it means. On the first day, they're just blown out of the water by the diagnosis," Sveningson says.

She reviews the pathology report with patients and sends them packets of information about breast cancer and treatment options.

"I can meet with them in person, but since so many live a distance away, I do a lot of work on the telephone," Sveningson says.

The health system serves a large rural community in parts of North Dakota, South Dakota, and Minnesota, and some of the women who come to the clinic live as far as 200 miles away.

Sveningson does an initial intake assessment and enters the information into the health system's computerized charting system. The assessment includes their concerns and goals and any barriers to appointments.

"The surgeon can look at the information and know what we know about the patient," she says.

Depending on the diagnosis, patients may need a surgical consultation or a medical oncologist consultation. Sveningson helps set up an appointment and coordinates, whenever necessary, with the patient's primary care physician.

Before the program started, patients would get the initial diagnosis and then have to wait seven to 10 days to see a physician for follow-up.

"They would get information from friends or go onto the computer and search for themselves. We were concerned about whether they were going to get reliable information from a reputable web site," she says.

Sveningson helps patients navigate through the complexities of the health care system. She explains the treatment options and gives the patient the information that will help them choose the option that's best for them.

"A lot of it is knowing that what they are feeling is normal and that it's not unusual for people in their position to have problems sleeping or eating," she says.

Sveningson prepares the patients for the surgical consultation, educates them about what to expect from the appointment, and gathers the information a surgeon may need when seeing the patient.

She often accompanies the patients when they see the surgeon and follows up later to clarify any information they don't understand and answer questions. "We are available to be their second set of ears when they see the surgeon. Some people don't want us there, but we try to touch base and make sure the surgeon is aware of their story," Sveningson says.

Patients are encouraged to call

She encourages the patients to call her with questions and concerns, but she also calls them at regular intervals.

"Women are very overwhelmed by the diagnosis of breast cancer. We have this culture of stoicism that says you handle whatever is thrown your way. They won't always call and say they need help. When I call them, they appreciate it greatly," Sveningson adds.

A lot of patients are afraid to bother someone by calling with questions, or they may call and the surgeon isn't available to talk. The breast cancer case managers often can answer the questions, she adds.

Once the patient has had surgery, Sveningson starts preparing them regarding what to expect for their consultations to medical oncology and radiation oncology.

After patients receive a treatment plan, Sveningson follows up to help them understand the complexities of the cancer treatment.

"Patients often don't understand the treatment plan, and they are fearful of having chemotherapy and radiation. I'm able to re-emphasize how cancer is staged and how a treatment plan is determined. I give them the message that breast cancer can be cured," she adds.

Contact with the breast cancer case manager tapers off when the patients' postsurgical treatment begins.

"By the time they start chemotherapy, they have gotten through the major complexity of navigating the system and they need to be followed closely by medical oncology. At that point, most of their questions are related to their treatment," Sveningson reports.

Since the position was established, the health center has not received any complaints or negative feedback from breast cancer patients. A patient satisfaction survey showed high satisfaction with the program.

"We know that if one person has a negative experience or feels like they fell through the cracks that they are going to tell 10 people. We are here to make sure that doesn't happen," Sveningson says. ■

DM outcomes key to improving nation's health

Measuring only return on investment not enough

Extensive outcomes studies to document the value of disease management are necessary to convince the health care industry that disease management is a viable solution to gaps in health care and poor outcomes for people with chronic diseases, asserts **Derek Newell**, vice president of outcomes measurement and product manager for LifeMasters Supported Self Care, an Irvine, CA-based disease management company.

"There is a lot of scientific knowledge among the academic and scientific community about what tests and treatments result in optimum results for people with certain conditions. But there's a big difference in what we know and what we do. Disease management is designed to help close that gap," says Newell, who directs LifeMasters' new outcomes research group.

Disease management is still in its infancy, and only a tiny faction of health care expenditures are for disease management, he points out.

"There still have not been large-scale trials to document the value of disease management. We need more and better research on outcomes of disease management to convince the market that this is a viable solution to our current situation," Newell adds.

Clinical literature and research are far ahead of actual practice when it comes to improving the outcomes for people with chronic diseases, he states.

"The clinical literature is there to support disease management, but the health care industry isn't sure how to tackle the problem. Everybody is certain that the status quo is unacceptable, but they aren't sure how to change it. Outcomes research and reporting may point the way," Newell says.

Outcomes measurements are important in disease management not only to demonstrate the cost-effectiveness of the program but to show which interventions are most efficient and effective, he adds.

"If you're not measuring outcomes, you're not doing disease management," Newell flatly says.

LifeMasters monitors external outcomes, including financial outcomes and clinical outcomes, to show that they are meeting their customer expectations, and internal outcomes, which they use to make program improvements.

Return on investment is an important outcome to measure in disease management programs because it goes to the people who are going to approve the expenditures, Newell points out. "It isn't about convincing the clinical people. It's about convincing the financial people," she adds.

However, he concludes, the real outcomes are human outcomes and clinical outcomes. "Financial outcomes are usually done on an annual basis. You need to track clinical outcomes in order to learn how to maximize the effectiveness of the interventions," he says.

The Health Plan Employer Data and Information Set measures are among the key clinical indicators of success every disease management program should measure, Newell adds.

But outcomes measures should go further and track other interventions that are a key to managing a disease but may not be as easy to measure, he adds.

For instance, in addition to the better-known indicators for diabetes patients, LifeMasters tracks hypertension control, often a problem with diabetics.

LifeMasters reports to its clients on factors

such as patient interventions, physician interventions, educational calls, and other processes.

"We show what interventions we make, what the activities are designed to affect, and how they affect them," Newell notes.

The interventions and reports differ in different diseases.

In addition, LifeMasters tracks internal outcomes to shows which activities are most effective in improving patient outcomes.

For instance, among its patient bases, LifeMasters has tracked whether particular types of interventions, such as mailings or telephone calls, are most effective in encouraging participants to go for a recommended test.

Global lessons

The company test-markets various materials to see how many people respond to each type and if they get better results when they offer the members a financial incentive.It also tests to see if the most effective type of letter comes from the patient's physician, the patient's health plan, or the disease management company.

"We do a lot of analysis around different types of interventions and what is effective, even to the point of analyzing results by call centers, by health plans, and by clinical professionals. When you have data on hundreds of thousands of people, you can find out things you can't find out from a small group," Newell says.

If the data show that a particular case manager is performing extremely well, the company sends someone to interview her about how she works with her patients and what she does to motivate them to comply.

"We look for global lessons that we can build into training or methodology that we can put into a tool to improve the results for all our clients," Newell says.

The U.S. health care industry is made up of disconnected, disintegrated players with no real means to share knowledge, he says.

"The national guidelines say a person with a certain condition should be on a certain drug, but it doesn't happen. It may be that their physician didn't get the lab report or doesn't know that the clinical information exists.

The role of disease management is to coordinate the patient information and the appropriate treatment protocols and get them to the physicians, Newell adds.

"Our industry exists because the health care system is performing suboptimally. Our job is to increase the performance of the health care system as a whole by providing information to the various players when the health care system does not," he says.

For instance, new clinical guidelines are being issued almost daily, and physicians don't have time to keep up with the latest ones. In addition, there is no systematic way for a physician to get information about his patients who are not in compliance with their treatment plan.

"Physicians may not have a whole picture of the patients' health care services. They have what is in their chart, but there is no common medical record. We have access to all the data from all the providers the patient is seeing and can help the physicians manage their patients," Newell says.

When LifeMasters contracts with an insurance company for disease management services, the company starts to build a complete medical record for members using the insurance claims data.

The company supplements the information with the results of a 150-question questionnaire sent to members who are stratified into the disease management plan.

A good disease management program creates personal interventions for the members whose health it is managing, Newell says.

"When we get claims data that show a member with a certain disease is not on the recommended education, we get in touch with the physician and get the member scheduled for an appointment. We believe this is more effective than blanketing the physician with guidelines. We let them know the recommended treatment at the time they need to act on it," he adds. ■

The new frontier: Geriatric case management

Get ready to serve our aging population

America's aging population and increasingly complex health care system have given rise to a relatively new field — geriatric case management.

As the population ages, the need for geriatric case management will become more acute and the opportunities for skilled geriatric case managers will be greater, says **Kenneth J. Doka**, PhD, professor of gerontology at the graduate school of

the College of New Rochelle (NY) and consultant to the Hospice Foundation of America.

"We want to give quality care to the elders and give it in the most efficient and desired way, primarily in an at-home setting. The role for the geriatric case manager in facilitating this can be very useful," he says.

Case managers are a critical link in the health care system because they can coordinate all the services that seniors need and help them live a quality life, Doka adds.

Opportunities to increase

"Case managers can sell their role as a solution to the problems that aging Americans face. They can give people with chronic illnesses their best advice to help them marshal their resources, maximize their health, and make effective choices," he adds.

Bruce Brittain realized there was a need for his geriatric care management company, Wisdom River Partners, because of his experiences coordinating his elderly parents' and in-laws' care from a distance.

"Our company emerged primarily because of the unprecedented aging of the U.S. population, the fragmentation and complexity of the health care and social care systems available, and the scattered nature of our culture," Brittain reports.

In the past, elderly relatives were cared for by younger family members or neighbors, he points out.

Now, many seniors move to retirement communities, leaving their children hundreds of miles away, or families are transferred across the country, leaving their parents behind.

"Adult children often feel they are not doing enough for their parents. They have to cope with multiple doctors, dozens of pills, failed driving tests, short-term memory lapses or more serious declines, unusual purchases — and then there's the whole home health care or assisted-living alternatives. It's very frustrating, stressful, and often beyond the knowledge base of most families," he adds.

The company contracts with families to provide geriatric care management for seniors living in the greater Tampa Bay, FL, area.

"Geriatric care management is only about 20 years old, and it has been mostly a cottage industry. We are running our company with an eye toward growth and the ever-increasing need for our services," Brittain says.

As the population ages, the baby boom generation is spending more time trying to cope with their parents' health care needs.

Geriatric case managers can be a big help to families, but they should tread softly, Doka suggests.

The baby boom generation doesn't want to be told what to do or what to do for their parents. Instead they want to have all the options laid out for them, he says.

"The fact that a case managers has a title or degree won't necessarily convince baby boomers to take their advice. They should be ready to defend their recommendations," Doka adds.

The opportunities for geriatric case management will only increase, points out **Geraldine Go**, PhD, APRN, clinical association professor of nursing at the College of New Rochelle.

"Right now, it's not unusual for people to live to be 80 or older, and that is going to increase in the next decade or so," Go says, adding that within the next 20 years, more than 20% of the population will be 65 or older.

In the future, case managers will be dealing with clients who are older and more ethnically diverse.

The aging population is more educated and better off economically than they have been in the past, Go says. The downside is that the younger generation is not likely to be available to take care of older parents or relatives because of their careers, she adds.

"The idea of an older person being cared for at home by a full-time homemaker is a rarity. We now need to look at alternative living arrangements for older people," she says. **(For information on a web site that helps caregivers find living arrangements for seniors, see related article, right.)**

Go foresees an increase in the need for adult day care services, assisted living facilities, and independent living facilities for older people.

"They tend to be expensive and insurance doesn't pay for it, so families are going to have to pay out of pocket," she adds.

Case managers need to strengthen their teaching role and work with clients to help them prevent illnesses, in addition to working with them when they are sick, she says.

End-of-life issues

"It's important for the insurance industry to focus on health promotion rather than waiting for people to get sick and then paying for it," Go notes.

The aging of the population means that people are more likely to have chronic illnesses.

"If people don't have a health care background, how can they know how to prevent illnesses? It's rare for a doctor to have a half hour to go over everything a patient should do, what he should be eating, or other steps to take to stay healthy. It's up to the case mangers to emphasize the education piece," Go says.

Case managers should urge their older clients to take care of estate planning, insurance benefits, advanced directives, and other paperwork they probably have been putting off.

It's always better to make end-of-life decisions, such as advance directives and advanced care plans at a time when you're not emotionally overloaded, Doka adds. ■

New tool evaluates living and care options for seniors

Web site educates and empowers caregivers

Case managers and others who work with senior citizens have a new tool to help them advise their clients on appropriate care or living decisions.

CarePlanner is a web site and on-line tool to help people make decisions about care for the elderly or disabled, based on their situation and preferences. The purpose of the tool is to educate and empower caregivers to make appropriate decisions, including keeping seniors at home if possible, says **Meghan Coulehan**, MPH, research project director for CarePlanner at Clinical Tools Inc., a health care management company that developed CarePlanner through a grant from the Centers for Medicare & Medicaid Services.

The CarePlanner asks users a series of questions about the senior's age, gender, current living environment, and state of residence. It includes questions about financial issues, health status, treatments, ability to carry out activities of daily living, personal preferences, such as doing their own cooking or sharing a bedroom, and the availability and health of any caregivers.

Based on the selections, the CarePlanner creates advice reports analyzing the senior's potential for successfully living in each of seven living and care options. They include home care, retirement community, continuing care community, personal care home, assisted-living facility, nursing home, and hospice care.

The tool includes links to other agencies and organizations that can help in implementing the plan.

"It doesn't tell people what the best option might be. It gives them recommendations for successful placement," Coulehan says.

The CarePlanner aims to educate seniors, their families, and care givers about community-based and home-based health care options, with an

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emphasis on options that provide care at home, she adds. "Most people don't know about all the resources that are available. If Mom falls and breaks her hip, the family thinks the only option is to put her in a nursing home," Coulehan says.

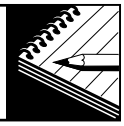
The tool is designed for seniors, physically disabled individuals with a chronic illness who need supportive services, and their caregivers, case managers, social workers, and families.

The care planning process tends to be overwhelming, Coulehan comments.

"A lot of times, people become caregivers because of a sudden event. They know nothing about care giving options, or making arrangements and it's dumped on them all at once," she adds.

For more information, see the CarePlanner web site at www.careplanner.org. ■

GUEST COLUMN



CMs are gatekeepers of their own conduct

They are accountable, regardless of area of practice

By **Carole Stolte Upman**, RN, MA, CCM, CRC, CDMS, CPC
Chair, Committee on Ethics and Professional Conduct
Commission for Case Manager Certification

Case managers today work in a broader range of venues than ever before. Professionals from a variety of backgrounds are finding that they, too, are practicing in the case management field.

These two powerful forces of change are intersecting at a critical point: The need for all case managers and those who practice in the field to become the gatekeepers of their own professional conduct.

This means that no matter what other affiliations a professional may have, anyone practicing in the case management field also must be accountable to the Code of Professional Conduct for Case Managers. For example, a case manager might specialize in workers' compensation, social work, group health, or an area such as hospice.

Whatever the segment of the field, the individual must practice within the parameters of his or her professional designation and also must comply with the Code of Professional Conduct for Case Managers.

In recognition of the changes in the case management, the Commission for Case Manager Certification (CCMC) is revising its Code of Professional Conduct. The purpose of the revision is to ensure that the code reflects all aspects of case management and the multiple areas in which it is practiced. A draft document has been posted on the CCMC web site (www.ccmcertification.org), and feedback is being sought from all case managers — including certified and noncertified individuals. (All feedback must be received by Oct. 31.)

Given the complexity of the case management field, it's easy to see how ethical questions could arise. In my particular areas of specialty with seniors and catastrophically injured workers, there can be instances in which an inexperienced case manager could inadvertently cross the line of ethical behavior.

Let's take a hypothetical example: A new case manager working in the field has a high degree of autonomy. The case manager has a discussion with an insurance company adjuster regarding a seriously injured worker, whom we'll call "Mr. Smith."

The insurance adjuster tells the case manager, "You had better write a letter to Mr. Smith and tell him that if he doesn't cooperate with the case management process, we're going to discontinue his benefits."

If the case manager follows that directive, however, he or she is threatening Mr. Smith — even if such action is completely inadvertent. The case manager could be well intentioned in notifying the injured individual. Nonetheless, such an action would be outside the realm of professional practice.

No one wants to be called accountable by peers and/or the justice system as to why he or she did not practice in compliance with the Code of Professional Conduct for Case Managers. Ignorance of the code or how it applies is not a reasonable defense. Furthermore, as a standard of ethical behavior for the field, the Code of Professional Conduct for Case Managers can be applied to all case managers — those who are certified and those who are not — in litigation. (The CCMC, however, can only use its code in handling complaints against individuals who have the CCM certification. CCMC has no authority over case managers who are not certified and violate the code.)

Case managers must hold themselves accountable in full awareness of what is expected of them. Here are a few tips to help case managers ensure that they are complying with the highest standards of ethical standards:

• **Review the Code of Professional Conduct for Case Managers and other professional codes on a regular basis.** For example, each time you apply for continuing education credits from a particular organization (such as the CCMC), review the code or ethical standards of that group. What standards are you being asked to live by? Are there any areas of conflict for you? Do you need clarification about a particular matter?

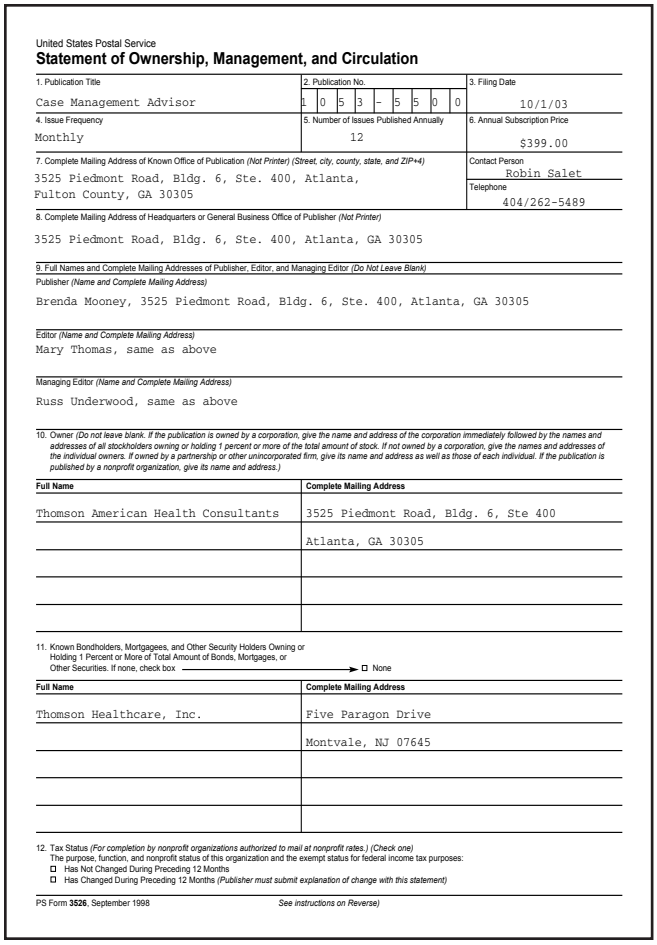
• **Understand what other professional or ethical guidelines you also are expected to follow.** If you are also a nurse, for example, you must be aware of the implications of the Nurse Practice Act. The dual nature of your professional role — as both a nurse and a case manager — means that you have to practice according to the standards of two professional codes.

• **Develop a "red-flag" system.** For some people, it comes with experience. But most of us have some degree of an innate sense that serves as a kind of warning when something doesn't "feel right." If a particular circumstance raises that kind of red flag, pay attention! If you are being ask to do or say something that raises that red flag, make sure that it is in accordance with the Code of Professional Conduct for Case Managers as well as any other applicable professional codes or standards.

The heightened awareness of ethical and professional conduct issues should not be viewed as a burden on case managers. Rather, the Code of Professional Conduct for Case Managers helps to distinguish you as a professional who adheres to the highest standards to the benefit of the clients you serve and the rights of those whom you must protect.

In future columns, the CCMC will explore ethical issues for various areas of the case management field. We welcome your questions and feedback, by contacting us at info@ccmcertification.org.

[Editor's note: Carole Stolte Upman is Immediate Past Chair of the CCMC and Chair of its Committee on Ethics and Professional Conduct. In addition, she is founder and president of Chesapeake Disability Management Inc., and director of Maturity Concepts: Care Management & Consulting, both of Towson, MD. For more information or to obtain an application for the CCM, contact the CCMC at (847) 818-0292 or see the web site at www.ccmcertification.org.] ■



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PS Form **3526**, September 1999 *(Reverse)*

Increased screening could ID more diabetes cases

Almost all of the 5.9 million Americans who have diabetes but don't know it could be identified if people with just one risk factor are screened for diabetes, researchers at the University of Texas Medical Branch at Galveston say.[1]

Screening patients with just one risk factor would catch almost 100% of new diabetes cases if existing guidelines were followed, the researchers conclude. Screening people with two or more risk factors would help detect 98% of the cases and would reduce the number of tests that have to be performed. The study was published in the *Proceedings of the National Academy of Sciences.*

Reference

1. Dallo F, Weller SC. Effectiveness of diabetes mellitus screening recommendations. *Proc Natl Acad Sci* 2003; 100(18): 10,574-10,579. ■

CE*questions*

21. In the first nine months of Anthem Blue Cross and Blue Shield's proactive case management pilot program, what was the difference in total cost of care between the control group and the intervention group?
A. 10%
B. 15%
C. 13%
D. 20%

22. When do breast cancer case managers at MeritCare in Fargo, ND, make the first telephone call to the patients whose care they manage?
A. Within a few minutes after diagnosis
B. After the surgical consultation
C. Within a week after diagnosis
D. Following surgery

23. According to LifeMasters Supported Self Care spokesman Derek Newell, outcome measures in disease management should demonstrate the cost-effectiveness of the program and show which interventions are most efficient and effective.
A. True
B. False

24. The experts agree that geriatric case management will grow by leaps and bounds as the baby boomers age. Twenty years from now, what percentage of the population is expected to be 65 and older?
A. 15%
B. 20%
C. 50%
D. 33%

25. According to Carol Stolte Upman, what should case managers do to ensure that they are complying with the highest ethical standards?
A. Review the Code of Professional Conduct for case managers regularly.
B. Understand the other professional and ethical guidelines under which you must operate.
C. Pay attention to the "red flag" that warns you when something doesn't feel right.
D. All of the above

Answers: 21. C; 22. A; 23. A; 24. B; 25. D.

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. ■