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Help your clients ensure their end-of-life wishes are met

Act now to avoid difficult, costly dilemmas

You might not encounter an end-of-life issue as dramatic as the recent Terri Schiavo case, which pitted the husband against the parents and prompted a special law passed by the Florida state legislature.

But regardless of your practice setting, you are likely to encounter critically or chronically ill patients whose last days may be complicated by the fact that they haven't let anyone know their wishes for end-of-life care.

That's why case managers should make conversation about advance directives part of every case they are working on, regardless of what is going on or what diagnosis the patient has and not wait until the patient is in a life-or-death situation.

"I feel that these conversations should be a routine part of a case management assessment and integrated into our health care culture as a whole," says **Catherine Mullahy**, RN, CRRN, CCM, president of Options Unlimited, a Huntington, NY, case management company. "Death is not an option, even though most Americans choose to ignore the natural human process that will profoundly affect them and their families."

Case managers typically deal with people with multiple conditions who could run the risk of being in the same position as Terri Schiavo, points out **Judith Black**, MD, senior products medical director for Highmark Blue Cross and Blue Shield in Pittsburgh.

Through an advance care initiative begun in 2000, Highmark Blue Cross and Blue Shield case managers take the lead in bringing up end-of-life planning in their discussions with members. **(For more details, see related story, p. 3.)**

"For a case manager to be effective in helping families avoid what is going on with the Terri Schiavo case, they need to learn a lot of communication skills so when they have the conversation with the patient and their family, they can ask the right questions," she says.

One scenario a case manager may encounter could be an individual with advanced Alzheimer's disease who is not eating. The case manager or physician approaches the family about a feeding tube. If the older adult hasn't talked to anyone about his or her wishes, the family members could be divided on the issue.

"What we try to do is encourage all members to talk to their family and loved ones about what they would want if they couldn't make a decision and to identify one person who would step in for them," Black says.

If a patient already is in the hospital and the case manager is asked to talk to the family about what their wishes are, it's probably too late to help the family avoid a lot of heartache, says **Michael J. Demoratz**, PhD, LCSW, CCM, a case manager in private practice who specializes in care for catastrophically ill patients.

"When a loved one is in the hospital, it's probably the worst time for people to make a decision about what they want. They aren't thinking clearly, and any decision is covered with emotional overtones," he adds.

In those cases, if the family makes the decision not to do something, the patient is likely to die. If they make the decision to do something medically, the patient may suffer, Demoratz says.

Asking people with end-stage emphysema if they want to be on a ventilator to help them breathe when they already feel like they are suffocating may not be the time to address it, he notes.

On the other hand, if the issue is covered well in advance, a patient could direct to have treatment options that would alleviate the experience of suffocation and allow for a more peaceful, dignified death, if that is his or her wish, Demoratz adds.

In the Schiavo case, there is nothing in writing, so there is no way the health care providers can know what her feelings are, Demoratz points out.

"It's one thing if a patient has made the decision clear, but in the case of Terri Schiavo, there is nothing you could say to the parents to convince them that was true. We need to be very cautious of going down the path of removing the feeding tube of a patient who hasn't made his or her wishes clear," he says.

Through the years, Demoratz has worked with a number of patients who were in a similar state of health as Schiavo's and, in some cases, the parents were fighting the spouse about what should happen.

"If the patient has something in writing, I am adamant in supporting their wishes. It's making the decision in light of not knowing where we get into trouble," he says.

The Patient's Self Determination Act of 1990 requires health care facilities to provide written information to patients about their right to refuse treatment and the right to create advance directives for health care.

In a typical scenario, a patient receives information about advance directives and the right to refuse treatment when he or she is being admitted to the hospital, and treatment issues are given short shrift, Demoratz points out.

"The person who does it is a clerk. It's the wrong time using the wrong person for the wrong reason. The discussion of a patient's

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Editorial Questions

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

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wishes regarding treatment is more than a five-minute presentation of a paper requiring a signature. It should be a well thought-out conversation by a physician who understands the requirement and has the time to devote to questions that arise, or if not the physician, a specifically trained health care professional," he adds.

Because case managers are in contact with patients, families, and provider teams on a regular basis, they have ample opportunities to bring up the subject with their clients.

"Case managers are perfectly positioned to be the leaders and advance guard in providing the much-needed education on end-of-life issues, not only to patients and families but also to fellow medical practitioners," Mullahy says.

Documents necessary for advanced care planning include advance directives, a written plan that lets health care providers know what kind of care the person wants, a health care power of attorney that designates a surrogate to make treatment decisions if the patient can't make them, and a living will, an advance directive that goes into effect only if the patient has a terminal condition or a state of permanent unconsciousness.

The Physician Order and Life Sustaining Treatment (POLST) tool, developed by Oregon Health & Science University in Portland, is another tool that Black suggests case managers review as they talk to their clients.

The POLST form, designed for patients who have a serious health condition, asks a series of specific questions about care, including whether the patient wants resuscitation, medical interventions, antibiotics, or artificially administered fluids and nutrition.

The tool is intended to ensure that physician orders are followed when the seriously ill patient is transferred across care settings.

"It doesn't replace an advance directive but facilitates the patient's and family's wishes being honored," Black says.

(For more information on the POLST, visit the web site: www.ohsu.edu/ethics.) ■

Don't avoid bringing up a difficult subject

Talk to your clients about advance care planning

End-of-life care may be the most difficult subject you'll take up with your clients, but you'll be doing them a big disservice if you don't discuss it.

"A lot of it boils down to people being able to communicate on topics they don't want to talk about, but people need to know that if they don't talk about it, they don't get what they want. If they don't tell someone the fact that they don't want to be kept alive on a ventilator, they will be kept alive on a ventilator," says **Michael J. Demoratz**, LCSW, CCM, PhD, a case manager in private practice who specializes in care for catastrophically ill patients.

Demoratz suggests bringing up the subject of advance care planning gradually with your clients and raise it again until they make a decision.

Some people, particularly older people, think that if they have an advance directive they won't get treatment. That's why the conversation needs to be part of every initial interaction by case managers, Demoratz adds.

Questions that should be addressed include use of ventilators and other equipment, artificial feeding and hydration, antibiotics, cardiac medications, pulmonary resuscitation efforts, and whether to be transferred to a hospital emergency department.

The conversation always takes more than 15 minutes when it is first initiated, so allow plenty of time, Demoratz says.

Discuss with the client and family where they are in understanding the disease process, suggests **Judith Black**, MD, senior products medical director for Pittsburgh-based Highmark Blue Cross and Blue Shield.

Determine if patients understand whether they will get better and whether the treatment they are considering will help them meet their goals, Black advises.

"The case manager can be a facilitator to help the patient and family make the right decision," she says.

Recognize that end-of-life decisions are a process and not just a one-time issue.

"People shouldn't think they can complete the form and they're done. All health conditions can change," Black says.

Encourage your clients to designate an individual to make health care decisions for them and to talk to that person about what they want. "Sometimes the member has designated someone to make the decision, but they never talk to them," she says.

If a client says his or her advance directives are

in order, gently ask him or her to show you proof.

"When they meet face to face with a patient, I suggest that case managers ask to see all the medications a patient is taking rather than simply asking if they are taking their pills. In the same way, I would ask to review the advance directives with a patient to make sure they are up to date and complete, comments **Catherine Mullahy**, RN, CRRN, CCM, president of Options Unlimited, a Huntingdon, NY, case management company.

Be prepared for clients who resist discussing the subject. For instance, young people may shy away from the subject or feel that they don't need to act.

When she talks to her clients, Mullahy compares the preparation of advance directives to the wisdom of preparing a will and reminds them that such measures are wise for everyone, from newlyweds to retirees.

With older clients, who may fear losing control of their own lives, Mullahy points out that the medical directives are a kind of insurance policy that enables individuals to take care of their own medical futures and remain the decision maker regarding their health care.

Be aware that you may encounter unspoken misperceptions about why you are raising the end-of-life issue.

"When a case manager represents a managed care organization, she is sometimes met with skepticism or cynicism about her motives in asking certain questions. Because of our close affiliation with money matters, case managers should anticipate some resistance, not only due to talking about death but also due to the feeling that we might be more interested in holding onto health care dollars than in appropriate care," she says. ■

CMs guide members on end-of-life decisions

Insurer's initiatives include education for staff

When case managers at Highmark Blue Cross and Blue Shield bring up advance directives with their patients, they are well prepared.

The insurer has developed a comprehensive plan to increase awareness of advance care planning by working with community groups, educating health care providers, and guiding members through the process.

"We wanted to respect our members' choices regarding advance care planning, whether they wanted full treatment or limited treatment. We want to make sure our members know that there are options in a terminal illness. Our goal is to avoid last-minute indecisions," says **Judith Black**, MD, senior products medical director for the Pittsburgh-based insurer.

Before Highmark Blue Cross and Blue Shield started its advance care planning initiatives in the summer of 2000, the insurer created an educational process for the staff.

Highmark developed a training video for case managers and care managers to help them talk to members about advance care planning and the difference between comprehensive planning and just having advance directives in place.

The video includes role-playing by staff members showing scenarios between case managers and their clients when end-of-life issues are discussed.

The health plan did an assessment of case managers' comfort level with end-of-life topics before and after viewing the video. The comfort level increased after the video.

When the case managers meet for their weekly case presentations, one always is a case involving one of their highest-priority members for advance care planning.

When members are enrolled, the health plan sends them an advance directives packet and power-of-attorney form.

As they begin managing the care of the members, the case managers start discussions on the information in the packet.

Highmark Blue Cross and Blue Shield case managers are encouraged to stratify the members they work with into three levels of priority.

Those whose death within a year wouldn't surprise the case managers, typically about 5% of the caseload, receive the highest priority. In these cases, the case managers work to ensure that the patient's end-of-life wishes are in order and understood by their health care providers and family members.

When they work with members who are older than 65 or have a chronic illness, the case managers encourage them to have advance directives and a health care surrogate.

The rest are the members who are relatively young and healthy.

The case managers have been trained to find out what the patient and family understand about where they are in the disease process.

If they are not sure, the case managers talk

with the patient's physician to make sure everybody is on the same page, Black says.

The health plan's case management documentation software includes a template on which case managers can check off whether a member has advance directives. If other case managers get involved in the patient's care, they know whether to approach the subject. ■

Take the lead in improving relationships with docs

Collaborate for better patient care

A good working relationship between a knowledgeable and effective case manager and a cooperative, clinically up-to-date physician can result in excellent, cost-effective patient care with superior outcomes and high levels of patient satisfaction.

But it doesn't always happen that way.

That's why **Frank L. Urbano**, MD, FACP, and **Pat Orchard**, CCM, CHE, set out to improve relationships between case managers and physicians at their hospital and put together a presentation: "Can't We All Just Get Along: Strategies for Developing an Effective Case Manager/Physician Relationship."

Urbano and Orchard met several years ago when Orchard became assistant vice president for case management at the Virtua Memorial Hospital Burlington County in Mount Holly, NJ, where Urbano practices and now is physician advisor to case management.

"Prior to that, I had no knowledge of what true case management was about. After research and with my own experiences working with the case managers at our hospital, I discovered that the major problem I saw was that there was a poor relationship between case managers and physicians," Urbano recalls.

The reasons for the poor relationship were twofold, he adds: Physicians felt that case managers were intruding on their time, and case managers didn't want to bother the physicians when they were so busy.

"In our hospital, I think that the physicians specifically work well with the case managers, but there still is that barrier to overcome. Physicians feel as though their way of practicing is being intruded upon and that what the case managers are trying to do is just one more thing they don't have time to handle," Urbano says.

Case managers need to take the lead in changing the perceptions that physicians have about the case management process, Orchard notes.

"There are very great opportunities for case managers to be a patient advocate if they are on the same page as the physician. There needs to be a change in the attitude of both parties. The person who is in the position to best change the attitude is the case manager," she says.

Good relationships are based on good working attitudes, respect, and trust, Orchard says.

"In order for case managers and physicians to get along, each must value what the other is doing, trust that what the other is doing is in the best interest of the patient, and understand what their respective role is in the diagnosis, treatment, and recovery of the patient," Urbano adds.

Case managers should approach physicians by telling them what they do, how they can help, and how their presence can benefit the patients and the physician, Urbano advises.

"Physicians are very much interested in what is best for the patient. Everyone should focus on what is best for the patient and not let ego and power get in the way," Orchard adds.

Respect the fact that physicians have multiple priorities and limits on their time and don't expect them to respond to you and you alone," she says.

When you approach physicians, concentrate on what is best for the patient, Orchard suggests.

"Physicians can identify more with doing the best for the patient than they can with insurance or workers' compensation mandates," she adds.

The best way to approach a physician is with evidence-based criteria and not just telling him or her that it is criteria set forth by a health plan, Urbano adds.

"The various criteria we hear about, such as Milliman [USA], are excellent, best-practice criteria, but when a physician hears that the insurance companies are using it, it automatically is suspect," he says.

Sometimes case managers carry the reputation of having a utilization review mentality, and they have to work to overcome that perception, Orchard adds.

"I find it offensive when case managers forget that they are clinicians and not technicians and they simply count days and justify stays. There's a lot more to case management than this," Urbano points out.

Case managers need to be aware of their skill limitations and know where they can get the information they need. If case managers delve into areas in which they don't have expertise, the physician can tell if they don't know the subject, Orchard points out.

For instance, case managers should be knowledgeable about the medication the patient has been prescribed before calling the physician about it, and if they don't know, they should have resources available to help them find out.

"Physicians don't expect case managers to be pharmacy experts, but they should understand drug side effects and other things that can help move the patient through the level of care," she says.

The worst thing a case manager can do is to be argumentative and confrontational, Urbano notes. ■

Program identifies at-risk patients early

Interventions are personalized to help patients

Traditional disease management programs that help patients manage their diseases after they become costly are like "arriving at the scene of an accident that has already happened," **John Palumbo** asserts.

That's why I-trax, a population health management solutions company, has developed proprietary health technology to identify people who are at risk for chronic disease before the disease develops and before they start to have a lot of insurance claims, adds Palumbo, who is vice chairman and president of the Philadelphia-based company.

"Everybody complains about increases in the cost of health care, but if we don't do something different, the funds are going to run dry. That's why we decided to reinvent disease management and to take a proactive approach to patient care," he says.

Traditional disease management programs concentrate on as few as 1.5% of members for each disease or 8% to 11% of the population base when all the major chronic diseases are covered, Palumbo says.

In a traditional disease management plan, the targeted patients are those whose health care costs already are high or who have been hospitalized or had an emergency department visit.

The I-trax Health-e-Life℠ program targets people who are likely to become traditional disease management candidates in the next few years as well as those who are actively diagnosed.

"It is critical for us to get people to enroll in the program, even if they are not spending a lot of money on health care," Palumbo says.

Instead of stratifying patients by using only a health risk assessment that identifies patients who are sick or likely to get sick, I-trax uses a proprietary health evaluation that identifies patients most likely to get a chronic disease.

The system takes the person's health information, patterns in care, and laboratory reports and is able to identify those who are likely to have a chronic disease.

Many of these patients never would have been in disease management because they have not had a claim.

"This means a patient who would never be in a high-intensity program because his or her claims were under $300 a year can be put into a program before the cost of care increases, instead of sitting under the radar," Palumbo says.

I-trax is the only health management company with integrated pharmacy management, he notes.

"We are shifting from acute to appropriate therapeutic medication therapy and medication compliance. It is more cost effective, and we often are able to dramatically reduce medication," Palumbo says.

The program can result in a 7% to 14% reduction in medical claims, he reports.

"We have the only patented scientific model which is powered by our scientific research partner, BioSignia, with actuarially validated claims and a patented clinical model that identifies patients prior to the onset of the disease," Palumbo says.

When I-trax begins to work with a patient population, many of whom are members of an employer's self-insured health plan, the company compiles several years of claims, laboratory information, and pharmaceutical history and enters it into a sophisticated repository. Members who are actively diagnosed or at risk are contacted by a nurse case manager, who conducts the health evaluation as part of the enrollment process.

Based on the information gathered by the nurse case manager, the system creates a proactive care plan.

"We treat people, not diseases. We design a personal care plan for every member in an

insured population rather than deliver a structured disease intervention based on a primary diagnosis," Palumbo says.

For instance, a patient may be overweight, taking medication for migraines, and has had a few claims for treatment for depression. The Health-e-Life program pulls together a resource library for the patient and develops a personalized care plan that is likely to include a weight management program and encouragement to see a psychologist.

I-trax calls its nurse case managers "nurse mentors." They work with the patients and encourage them to enroll in the mentor program rather than choosing self-care.

People with active diseases who need high-intensity interventions have a one-to-one relationship with the nurse. They are able to call the care communication system whenever they need to talk to their nurse.

Prospective health planning

The I-trax care coordination platform brings together physicians, nurse case managers, and patients, Palumbo says.

"Our system allows all providers to work together seamlessly by giving them data they couldn't get in another system," he says.

When patients are seeing more than one physician, there is no way for Physician One to know what happens when a patient sees Physician Three unless the patient brings the entire chart along, and the physicians don't know if a patient is compliant with the treatment plans they prescribe, he says.

Once a patient enrolls in the Health-e-Life program, I-trax compiles a list of all the physicians and contacts them.

I-trax shares any patient information it compiles with all of the physicians who are treating the patient. For instance, if a prescription was ordered and filled but not refilled, the system issues an alert that notifies the physician by telephone, mail, or through the Internet, whichever way the physician chooses.

"We are the only entity that can send lab data to all physicians. It is not legal for the laboratory to send the data to anyone other than the ordering physician," Palumbo says.

The nurses are assigned by employer group.

"Each employer group has their own issues, and some have their own interventions," Palumbo says.

The system generates a task list for each patient every day and automatically sends any information the patient or physician should be receiving. The members decide how they want to be notified.

I-trax uses an interactive voice system that patients can use to report weight, blood sugar levels, or other data.

If the patients don't call in when they're supposed to, the system alerts the nurse, who calls them. Physicians are alerted when there are problems, such as a sudden weight gain in a patient with congestive heart failure.

"This is a fundamental shift to prospective rather than reactive health planning, supporting physicians like never before," Palumbo says. ■

Health plan targets members at risk for suicide

System picks up cues often missed by clinicians

Clinicians at PacifiCare Behavioral Health use a variety of techniques to identify patients who may be at risk for suicide, beginning with a member's first call to the managed behavioral health plan's behavioral health line, which is staffed by customer service associates trained to identify members who need immediate interventions.

When patients are in treatment, the health plan uses its ALERT (Algorithms for Effective Reporting and Treatment) system to assist clinicians in identifying members who may be at risk for suicide.

The ALERT system uses a 30-item Life Status Questionnaire, which patients complete in their practitioner's office on their first, third, and fifth treatment and every five sessions after that.

In addition, clinicians are asked to complete a one-page assessment form during the patient's treatment. Information on the patient's questionnaire goes into PacifiCare Behavioral Health's database system, where it is compared to information given by the provider.

Identifying patients

ALERT identifies patients who may be at high risk for conditions that have not been identified by the practitioner and automatically routes the data to the PacifiCare Behavioral Health care managers.

If the patient's assessment conflicts significantly with his or her therapist's, the care managers will

work with the treating practitioners to make treatment modifications, including increasing the intensity of treatment.

"If the ALERT program indicates a higher intensity of care is needed, we suggest that the member see the provider more frequently and authorize more treatment," says **Cassandra Loch**, LCSW, chief of staff for the Santa Ana, CA-based managed behavioral plan.

The ALERT system is used for members enrolled in the company's mental health and chemical dependency benefit programs who access behavioral health care services.

The ALERT database contains treatment patterns and outcomes data for approximately 100,000 patients.

Researchers at PacifiCare Behavioral Health developed the ALERT system following a three-year study involving 43,000 patients and 3,500 mental health providers. The study showed that clinicians miss early warning signs of suicides 57% of the time, compared with information in reports filed by patients themselves.

The rate dropped to 39% when clinicians were made aware of the differences between their assessment and the patient's responses.

Handling calls

Health plan data indicated that 4.5% of patients in behavioral health treatment are at high risk for suicide, chemical dependency, or premature termination of treatment.

About 8% of behavioral health plan members account for nearly half of all behavioral health treatment spending.

The staff at PacifiCare Behavioral Health's call center answer approximately 32,000 calls per month, Monday through Friday, 6 a.m. to 7 p.m. The number doesn't include after-hours coverage, which also is available for members.

Calls range from parents who want their child assessed for attention deficit disorder to people who are severely depressed, distraught, and suicidal.

The behavioral health call center team includes highly trained customer service associates and licensed care managers who manage benefits for several employer groups, unions, and health plans.

"If someone wants to access their mental health benefits, they can call us 24 hours a day and talk to one of our customer service associates, who are trained to triage the call and figure out what the potential risk issues might be," Loch says.

The customer service associates follow a standard questionnaire designed to determine if there are any risk issues.

If the associate thinks that a member may be at risk and needs immediate attention, he or she immediately transfers the member to a licensed clinical care manager, who completes a more in-depth assessment to determine the best referral.

The follow-up from this point depends on the needs of the members.

"A lot of people call when they are going through stress at work or home and need only a few counseling sessions. They are offered a referral to a practitioner in their area to contact for a routine appointment. Others who have a higher level of distress may not be able to wait for a routine appointment, so the care managers will assist in finding an appointment for an immediate face-to-face assessment," Loch reports.

The customer service associates are trained to figure out the specific needs of members and refer them to licensed clinicians, if necessary. If the member is not identified as needing to speak with a licensed care manager, the customer service associate can provide the member with a routine referral in the member's area.

When a call is transferred to a licensed clinician, an assessment is completed to determine the severity of the situation and whether the member needs to go to the hospital immediately or if he or she can be seen for a face-to-face evaluation within 24 hours.

Following up

In the more severe cases, the care managers follow up with the member and the provider and monitor the case until the member is stable and engaged in treatment, Loch says.

"We put our clinical resources toward the cases that need the most intensive care management. If a person sees a therapist for eight sessions for job or marital stress, we usually don't need to intervene in those cases," Loch says.

On the other hand, if a caller identifies him- or herself as suicidal, the staff immediately get in touch with a provider to set up a face-to-face assessment for the member.

The care manager will speak with the member and/or other family members to coordinate the appointment and to make sure that the member is seen. If necessary, the care manager may call the member every day until he or she sees the provider and gets into treatment.

Other members may be chronically ill, with fluctuating levels of distress. In these cases, the PacifiCare Behavioral Health staff may have contact with the provider and member on a monthly basis.

Long-term cases in which members have been hospitalized or are at a higher risk are contacted more frequently.

"People who are chronically, persistently mentally ill, who rely on the hospital as a primary source of treatment, are referred for case management services. We are always monitoring for any red flags that indicate a change in the treatment approach is needed," Loch says.

Staff training

In essence, the degree to which a care manager gets involved with a member's care is based on the clinical issues and needs of that member. The ALERT system helps to identify when and how care managers need to intervene by flagging high-risk cases for the care managers.

The customer service associates typically have a bachelor's degree and are required to go through six to eight weeks of training, including three weeks of classroom training, before they listen in on live calls. The training is a combination of learning the clinical system as well as role-playing and learning to identify members who may need to speak with a care manager by picking up cues.

"Members often won't say that they are depressed, but there are often clues that the customer service associate can pick up on," she says.

The customer service associates use a scripted questionnaire that is a combination of open- and close-ended questions.

"The computer system is so sophisticated that, based on answers to the questions, it prompts the customer service associates to transfer a call to a licensed clinician," Loch notes.

The licensed clinicians are all masters-prepared and are a combination of licensed clinical social workers, licensed marriage family therapists, and licensed psychologists.

The systems at PacifiCare Behavioral Health support the diverse needs of its patient population by the intense staff training. The staff are trained to customize their approach on cases based on the individual needs of the patient.

"We are constantly monitoring the clinical needs of our patients to determine the intensity and level of care management needed," Loch says. ■

GUEST COLUMN

Navigating the 'Bermuda Triangle' of ethics

Strategies for hospital case managers

By **Toni G. Cesta**, PhD, FN, FAAN
Commissioner
Commission for Case Manager Certification (CCMC)
Rolling Meadows, IL

Hospital case managers routinely face what I call the "Bermuda Triangle" of case management ethics. The top of the triangle is the clinical concern, encompassing the medical and treatment needs of the patient. On the right are the financial concerns, and on the left are the legal and ethical issues. In the middle of this triangle is the patient.

For the case manager, navigating this Bermuda Triangle is challenging, given the complexity of the issues and the ramifications that a decision in one area has on the other two. The best course of action is to fully understand the issues involved, to identify the ethical dilemmas, and to seek the advice of supervisors or hospital administration.

To further this understanding, let's consider each point of the triangle. Starting at the top, the clinical concerns relate directly to the needs of the patients that come into the acute-care setting. As care is rendered, one of the considerations is the length of the hospital stay, which will require a review to be given to the insurance or managed care company.

This brings us next to the financial point of the triangle. The hospital case manager must balance hospital resources and the length of stay with the needs of the patient. For example, let's say the targeted length of stay for a pneumonia patient is four days. The goal would be to optimize those four days so that treatment will progress according to plan.

What happens, however, if on the fourth day the patient is not moving along as expected toward the desired outcome? Perhaps there's a medical complication or a clinical setback. The insurance company recommends the patient be discharged and that intravenous antibiotic treatment be continued at home.

The hospital case manager, however, is concerned that the patient lives alone and may not be able to manage his or her own care cognitively or physically at home, even with a visiting nurse. After concerns are discussed with the insurance company, the recommendation still is to move the patient to home-based care.

This dilemma puts the hospital case manager at the third leg of the triangle, facing legal and ethical issues. The case manager does not believe it is appropriate to discharge the patient. Yet, keeping the patient at the hospital will mean that reimbursement will end. What should the case manager do?

As case managers, we sometimes are asked whether we advocate for the hospital or for the patient. I believe the correct answer is both, because we have to realistically balance the needs of both.

In practice, we always favor the needs of the patient, while keeping in mind what's best for the organization as well. The balancing act can be difficult, and hospital case managers should not try to tackle these difficult ethical dilemmas alone.

Case managers may seek guidance from the Case Management Society of America Standards of Practice, as well as the code of conduct or ethics to which they are bound by licensing or certification.

In addition, case managers can use their chain of command as a tool to find the best solution. For individual case managers, this means turning to the department director or manager to whom they report. Physician advisors also may be asked to speak to the insurance company as an advocate, urging that the patient's stay be extended.

For case management directors and supervisors, the issue can be escalated to hospital administration or the hospital's ethics committee.

As clinical, financial, and legal/ethical issues arise, more hospitals are turning to their ethics committees for advice. While these groups have often addressed end-of-life issues, we are seeing a growing trend toward the formation of organizational ethics subcommittees to address financial and reimbursement issues.

In the hypothetical example, if the insurance company would not authorize an extended stay, the hospital would likely absorb the additional costs. Legally and ethically, there is an obligation to keep the patient in the hospital until discharge is deemed to be safe. While this decision may be a costly one for the hospital, in this example the extended stay is determined to be the best and safest decision for the patient.

When it comes to ethical dilemmas that confront hospital case managers, here are some key points to keep in mind:

• **Identify the issues.** What clinical, financial, and ethical concerns are raised by a particular problem or scenario?

• **Use the chain of command as a tool.** Turn to your supervisor, manager, or hospital administration for advice. Seek the input of the hospital's ethics committee. Bringing together the viewpoints and input of representatives from various departments in the hospital will help to bring about the best solution.

• **If the hospital does not have an ethics committee or a committee that will take legal and reimbursement issues under advisement, urge the formation of such a group.** In a managed care environment, given the sharp rise in health care costs, ethical dilemmas related to reimbursement likely will become more common.

Most important, case managers should know they are not alone as they navigate through the perilous waters of ethical dilemmas. They have others to rely on for guidance toward the safe harbor of the best decision for all involved.

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

[Editors note: Toni G. Cesta, PhD, RN, FAAN, is director of case management at St. Vincent's Hospital in New York City. The CCMC has awarded the certified case manager (CCM) credential to more than 26,000 case management professionals since 1992. The CCMC is the only certifying body for case management professionals that is accredited by the National Commission for Certifying Agencies. URAC also has determined that the CCM credential is a recognized case management certification. For more information or to obtain an application for the CCM, contact the CCMC at (847) 818-0292 or visit the web site at www.ccm certification.org.] ■

Safeguard protected health information

CMSA, AAOHN offer guidance

Regardless of their practice setting, case managers need to take steps to maintain the confidentiality of protected health information under

the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

"Confidentiality of a client's protected health information is a professional obligation of nurse case managers to ensure public trust and prevent unauthorized and inappropriate disclosure," says **Jeanne Boling**, executive director of the Case Management Society of America (CMSA), with headquarters in Little Rock, AR.

CMSA and the American Association of Occupational Health Nurses Inc. (AAOHN) joined together to offer guidance to case managers and occupational environmental health nurses in protecting their employees' and clients' privacy rights.

Specific steps

The joint position paper addresses the privacy, legal, and ethical issues affecting case managers and occupational and environmental health nurses in all practice settings.

The document outlines specific steps that nurse case managers and occupational and environmental health nurses can take to ensure the proper handling of personal health information. They include:

- developing written policies and procedures regulating access, release, transmittal, and storage of all health information;
- implementing educational activities to inform clients, health care providers, and other appropriate individuals of their need to maintain confidentiality of client health records;
- obtaining legal guidance as necessary to aid in the interpretation of unclear practice situations;
- establishing and maintaining security standards for transmission and storage of employee personal health information;
- knowing state and local laws and company or facility policies that relate to the privacy and security of protected health information.

Organizations that are directly affected by HIPAA, called "covered entities" under the law, are health plans, health care providers, health care clearinghouses, and business associates of covered entities. This includes companies that help covered entities with treatment, payment, or health care operations, or contract with nurse case managers.

For instance, if a nurse case manager is working as an independent third party and engaged in treatment, payment, or health care operations for or on behalf of a covered entity, a business association relationship is created and the case manager is required to protect clients' health information under the rules applicable to the covered entity, Boling points out.

"The passage of the 1996 Health Insurance Portability and Accountability Act has validated the nurse's obligation to maintain confidentiality of health information," she adds.

There are some exceptions in which a covered entity does not have to get the individual's permission to disclose protected health information:

- **Treatment, coordination, or management of health care or related services by a health care provider.** For instance, when a nurse case manager coordinates client care, he or she is providing treatment and doesn't have to get permission to disclose the protected health information.
- **Payment or reimbursement to a health care provider for services and the process by which a health plan obtains premiums.** Nurse case managers employed by health care providers to assess whether needed services are eligible for coverage under an individual's health plan do not have to get permission from the patient to disclose information.
- **Health care operations, whether they are administrative, financial, legal, or quality improvement.** If a nurse case manager is employed as a health plan administrator, a plan case manager, or a utilization review nurse, he or she is performing health care operations and does not have to seek permission from the individual.

In all other situations, HIPAA mandates that covered entities obtain written authorization from an individual before disclosing protected health information, the paper states.

[A copy of the position paper is available at www.cmsa.org.] ■

COMING IN FUTURE MONTHS

- The ins and outs of neonatal case management
- Documenting case management savings
- Best practices in Medicare disease management
- Managing the care of people in other cultures

CE questions

1. The Patient Self-Determination Act gives patients the right to refuse treatment and to create advance directives for their health care.
A. True
B. False

2. According to Michael Demoratz, the initial advance directives discussion with your clients should take how long:
A. Five minutes
B. An hour
C. 15 minutes or more
D. 30 minutes

3. According to Frank Urbano, MD, what is the worst thing a case manager can do to contribute to a poor relationship with a physician?
A. Tell the doctor how to practice medicine.
B. Be argumentative and confrontational.
C. Talk about the doctor behind his back.
D. Tell the patient you disagree about the diagnosis.

4. What percentage of patients in the PacifiCare Behavioral Health treatment programs are at high risk for suicide, chemical dependency, or early termination of treatment?
A. 10.2%
B. 30.9%
C. 1.3%
D. 4.5%

5. Toni Cesta's definition of the "Bermuda Triangle" of case management ethics includes what components?
A. Clinical concerns, financial concerns, legal and ethical issues
B. The best interests of payers, providers, and patients
C. Doing what's best for the patient or keeping your job
D. Pleasing your boss, the payer, or yourself

Answers: 1. A; 2. C; 3. B; 4. D; 5. A.

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. ■