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An array of resources helps case managers work effectively

Program reduces cost by $12.3 million in six months

By creating a series of tools and other resources, Premera Blue Cross has been able to increase the efficiency of its case management department and earn coveted accreditation from Washington, DC-based URAC.

The case management program at the Mountlake Terrace, WA, health plan is one of only two in the state of Washington to achieve URAC accreditation. The health plan covers members in Washington and Alaska.

Premera estimates that its case management program reduced its costs by about $12.3 million during the first six months of 2003. During the same period, the insurer estimates that it reduced members' out-of-pocket expenses by $3.4 million and the amount paid out by self-insured employees whose plans are administered by Premera by $5.1 million.

"Members say our case management nurses provide comfort and security during a very difficult period. We're also learning that these efforts to enhance quality of care and member satisfaction can lead to more cost-effective care," says **Roki Chauhan**, MD, Premera's vice president for medical services and medical director for quality.

Weekly meetings to discuss troublesome cases, a case management assessment tool, a database containing appropriate goals for most diagnoses, a database of community resources, and a detailed set of policies and procedures are among the resources that case managers can use in managing their cases.

"We've had many new case managers join us in the last year or two, and they are really impressed about the tools we use," says **Maureen Leyva**, RN, CCM, case manager and team leader for the health plan's federal employee program.

The department's weekly case presentation meetings were named a "best practice" by URAC accreditation reviewers.

Case managers from all parts of the health plan's coverage area participate in the weekly telephonic case presentation meetings, which

are attended by at least one physician advisor, a behavioral health specialist, and a pharmacist if warranted.

Case managers may present a troublesome case on which they need advice, an ethical issue, or share information they have learned that will help other case managers.

The meetings are limited to one hour a week.

"It is my firm belief that the meetings do not go longer than an hour because they need to be managing their cases," says **Mary Murray**, RN, CCM, CPHQ, manager in care management with primary responsibility for the case management program.

The insurer's 50 case managers are divided into three teams, each of which holds a separate meeting with some participants connected via telephone. The teams are organized to include members from each region's case management staff. Case managers who want to present a case at a meeting fill out a form describing the case they want to present and the issues pertaining to it.

The form includes the diagnosis, the background on the case, the case management plan, and the issue the case manager hopes to resolve. The forms are submitted in advance so the entire team can review them before the meeting.

The form was designed to prompt the team to focus on the issue at hand rather than getting sidetracked on other patient information, and begins with the question, "What is the issue?"

"When we first started, we had the history first and the issue at the end. We revised it to keep everyone focused. You have to say up front what the issue is or it may get lost in the discussion," Murray says.

The team usually tackles between four and six cases in an hour. Some are extended from one meeting to the next with the problem solving continuing over a matter of weeks.

If there are a lot of cases, people with the most urgent issues are allowed to go first. Those who are bringing a learning experience to share may wait a week if someone has a pressing matter to discuss.

"The case manager who asks the question, 'Where do I go now?' takes priority," Leyva says.

An administrative assistant on each team takes minutes, which are distributed to participants.

Case management staff attach the case meeting forms to the members' chart to demonstrate the collaborative discussion that takes place between the case managers and medical directors. The forms are put into a manual that case managers can refer to for information to use for other cases.

"The forms and the minutes of the meeting show the flow of the case and allow us to see the processes as a whole," Murray says.

In addition to patient care and discharge problems, the case managers often discuss ethical issues that arise with their cases.

Some of the ethical issues that have been discussed include conflicts in a family over end-of-life

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Mullahy (board member) discloses that she is editor of The Case Manager Magazine and president of Options Unlimited, the case management division of Matria Healthcare. Lowery (board member) discloses that she is a consultant to a wide variety of case management programs. Ahrendt (board member) discloses that she is a stockholder with Ahrendt Rehabilitation, Inc. and Ella Properties, LLC and is on the speaker's bureau of the Brain Injury Resource Foundation. Ward (board member) discloses that she writes occasionally for The Case Manager Magazine and AdvanceMagazine. Kizziar and Pegelow (board members) have no relationships to disclose.

Editorial Questions

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

issues and questions about why one provider refers only to a particular home health agency.

Team members often have information they believe the other case managers may find useful.

For instance, Leyva shared the information that the Society of Leukemia and Lymphoma will give $500 to cover copay, transportation, and other costs for patients with those diseases, regardless of their financial status.

The information also goes into Premera's case management department's extensive resource database of information on community resources for services that the plan ordinarily may not cover.

The resource database is especially helpful as case managers work with the member to find funding for procedures or tests that may not be covered under their plan.

"Each plan is purchased with benefit limitations. We work with the members to maximize the benefits they have and to identify other resources," Murray says.

When case managers begin a case, they use an assessment tool, a computerized script that helps them determine what their clients will need.

The tool covers everything from safety issues in the home to support systems, from activities of daily living to advanced directives.

"Just using the assessment tool is really helpful for new case managers. It includes triggers to make sure that everything you need is in place," Leyva says.

Over the past few years, the health plan has developed policies and procedures that ensure consistency among case managers in all coverage areas.

"I tell new case managers that if they do case management at Premera, they can do it everywhere. Our case managers are very much hands-on with their cases," Leyva says.

For instance, under the policies, case managers can't open a case without at least verbal consent and they pursue getting written consent.

The health plan receives high ratings on its case management satisfaction survey that is sent to members after the case is closed or every six month for longer running cases.

If somebody expresses a concern, the case manager's manager personally follows up with that person. For instance, as she prepared to close a case, one case manager left numerous messages with a family member who never passed them on to the member in case management. The patient complained in the satisfaction survey that she hadn't wanted her case closed.

After talking to her, the case manager reopened the case and set up a better way for the case manager to contact the member.

Premera's case management department includes a dedicated case management program for breast and lung cancer. The department has dedicated case managers for pediatrics, obstetrics, and behavioral health. The rest of the case managers are generalists who handle the rest of the cases but may fill in on a specialty case if the specialty case manager has a full caseload.

Premera case managers handle an average caseload of 35 to 40. Their contact with members depends on the acuity of the case.

Case managers generally manage the cases in their region, as long as the caseloads are manageable. For instance, if a case manager in Alaska has a maximum caseload, a case manager in Washington may take over and consult with the Alaska case manager for help with cultural issues.

Washington case managers may collaborate on community resources if they are handling a case in a different city.

When a complex case requires an on-site visit, the case manager who is closest to the patient does the visit. When a member has complex medical needs, the case manager will make a home visit. In these cases, Murray always cautions them not to put themselves into an environment where they won't be safe.

"I'm a firm believer that a picture is worth more than a thousand words. Sometimes, we hear one thing when we talk to a member and another when we talk to a provider. A home visit gives us a chance to identify what is going on," Murray says.

For instance, Leyva made a home visit to meet with a member who has amyotrophic lateral sclerosis (ALS) and couldn't talk on the telephone but wanted to communicate with her. His wife was on hand to help interpret what he was saying.

Time constraints are the only reason the case managers don't do more on-site visits, Leyva adds.

At Premera, members who would benefit from case management are identified from a trigger list that includes common diagnoses. Members who are hospitalized frequently or have major trauma or a diagnosis that needs a lot of care coordination also are referred for case management.

Once a case is identified, the case managers go through an evaluation process, talking with the member and provider and conducting a health needs assessment.

The programs are strictly voluntary.

Premera gets referrals from the internal staff, providers, members, and family members, Murray says. After the case manager calls the member and physician and conducts the evaluation of the case, the Premera case manager sends an introductory letter that explains the program and the member's rights and includes a case management consent form. The form gives the member the option to indicate that he or she does not want to be in case management.

Members receive a small brochure introducing their case manager with contact information.

"It's just a small piece of paper that they can put on the refrigerator or in another place where it will be handy when they need it," Murray says.

The case manager works with the member and primary care physician to decide on short-term and long-term goals.

The average length of a case is about four months. Some members, such as those with ALS or multiple sclerosis, are in case management much longer.

"When the case manager believes the case can be closed, she calls the member to discuss it and lets them know they can always call back and have their case reevaluated," Murray says. "It's hard for some members to give up the security of having a case manager who can help them answer complex health care questions. People do call us back, and we do reopen cases." ■

Expert witness can be new career path for CMs

Opportunities are increasing in litigious society

If you're looking for opportunities to enhance your case management career, consider becoming a case management expert witness.

"As case management comes under closer scrutiny in the legal system, there are more opportunities for case managers to be called on to speak on standards of practice, ethics, and other issues," says **B.K. Kizziar**, RN, CCM, CLCP, owner of B.K. and Associates, a case management consulting and life care planning firm based in Southlake, TX, and a longtime nurse expert witness.

An expert witness may be called by a plaintiff or a defendant. In some cases, both sides of an issue may call their own case management expert witness.

Case manager expert witnesses carry on with their usual caseload and only occasionally are called to be an expert witness. They are not "hired guns," a term used to describe full-time expert witnesses.

"Being an expert witness gives case managers experience in an area other than managing cases. It is a good way for case manager to broaden their horizons," Kizziar says.

Attorneys are looking for case managers who have the expertise to speak on case management standards and practice issues. The ones who have the work history and can demonstrate it are the most likely to be chosen, Kizziar says.

What do you need to become a case management expert witness? Education, experience, and professional credentials are essential, she says.

Case management expert witnesses should have achieved professional certification, Kizziar says, adding that CCM certification offered by the Commission for Case Management Certification (CCMC) is the gold standard among credentials.

"It's best to have a rounded case management job history in terms of working extensively in a particular field or working extensively in more than one field," she points out.

For instance, if you put yourself forth as an expert witness in hospital case management, you should have had a lengthy history as a hospital case manager and have supervised case managers in the hospital setting. State and federal rules of court require an expert witness to have "scientific, technical, or other specialized knowledge."

Your expertise must be directly related to the matter under consideration. You should testify only in the area in which you are qualified.

Academic credentials, including advanced degrees and special areas of study, membership and participation in professional associations, and publication of papers in your field of expertise also should be used to establish your credibility.

It's important to stay in daily practice as you pursue a career as an expert witness because it adds to your credibility, Kizziar notes.

"Case managers should continue to practice in the area in which they are holding themselves up as an expert. If someone hasn't worked in an area for a few months, it can affect their credibility because things change so quickly," she says.

It's important not to put yourself in the market as someone who sells out to the highest bidder, Kizziar adds.

In fact, she advises appearing for the plaintiff and defense attorneys during your career as an

expert witness to avoid being discredited as a "hired gun" who always works for just one side.

"It should not be apparent for which side the expert is working just by reading the written opinion or hearing testimony. The opinion of the expert should not change based on which side is paying the fee," Kizziar emphasizes.

In most of the cases you'll encounter as an expert witness, someone has been blamed for injuring someone else, Kizziar says.

For instance, a patient may claim that he or she was discharged prematurely from the hospital and experienced complications as a result or that the home care plan was faulty or went awry.

A case manager expert witness will be called on to describe the standards of care that happen in a typical case and how a prudent case manager should have acted.

"If a case manager is testifying as an expert witness to standards of care, the testimony should be consistent, regardless of which side he or she is on," Kizziar says.

For instance, if the issue is a hospital discharge plan that didn't work, the case manager would be likely to start her testimony saying, "In my experience, I have found this to be the case. . . ."

One typical kind of case in which a case manager may be called on to testify as an expert witness occurs when a patient is turned down for additional days in the hospital, goes home, and has a bad outcome.

The issue in these cases is: Is the insurance company to blame for the patient going home and having bad outcomes?

One part of the equation that people who are not in health care don't understand is that if a patient is turned down for additional benefits, the hospital or provider has an option to present more information, documentation, or literature to persuade the insurance physician reviewing the case to approve additional care.

"This is where the breakdown comes. Often the providers, for whatever reason, don't take advantage of that opportunity," she says.

In a case where the patient left the hospital because he didn't have additional benefits, the expert witness on the plaintiff's side would be called on to testify that the case manager in the hospital did everything she should have done but that because the insurance company wouldn't approve a longer stay, the patient had a bad outcome.

On the other side, the insurance company's expert witness might argue that the insurance case manager did what the patient's insurance policy required her to do by alerting the provider and inviting to contact the medical director with any additional information that might help gain approval for an additional stay.

"One expert might testify that the hospital case manager acted prudently, and the other might testify that the insurance case manager was doing what a prudent case manager would do," she says. "In these types of cases, it's very important to know that there is a fine line between an avoidable day and an early discharge." ■

Prepare carefully for your day in court

Be prepared for questions about your credibility

It sounds exciting to be an expert witness until you take the stand in court and the attorney for the other side questions your credibility, **B.K. Kizziar** asserts.

That's why she advises case managers who are interested in becoming expert witnesses to learn how the legal system works and be prepared for what they may encounter in a case.

"It would be a good idea to talk to someone who is an expert witness. It doesn't have to be a case manager, but it should be someone in the medical field," says Kizziar, owner of B.K. and Associates, a Southlake, TX, case management consulting and life care planning firm.

Start by learning about the legal system and how it works, Kizziar advises. Consider joining the American Association of Legal Nurse Consultants (www.aalnc.org), an organization that promotes the advancement of registered nurses consulting in the legal arena. The organization offers classes, periodicals, and a certification program.

Case management expert witnesses may be called in cases in which a case manager is not among the defendants, but Kizziar is quick to point out that no one should feel bad about testifying against someone in their field.

"I want my field to be considered a profession that includes only those who are practicing in an appropriate way," she says.

The testimony of a case manager expert witness focuses on the standards of practice, the standards of care, and the processes a prudent case manager follows.

Daubert rule affects expert witnesses testimony

Many states have adopted the federal court system's "Daubert rule" to determine the reliability of expert witnesses. The four components of the Daubert test are:

- The science can be and has been tested.
- The science has been subjected to peer review and publication.
- There is a known or potential error rate of the science.
- There is a general acceptance of the science in the relevant scientific community. ■

"The witness is not necessarily pointing a finger and saying the case manger did something wrong. We're just pointing out what all of us should be doing already as standard practice," she says.

When you make yourself available as an expert witness, in most cases, a plaintiff's attorney will contact you and ask for an off-the-record opinion. The attorney won't give out confidential information in the initial interview but will ask if you feel comfortable testifying in a particular type of case. For instance, he or she might ask if you have expertise in cases where a patient was discharged early with bad outcomes.

The plaintiff is the most likely side to have a case management expert witness, but in high-profile, critical cases, both sides usually call expert witnesses, Kizziar says.

In some cases, the defense may consult an expert and if they don't like what they hear, may decide not to call the expert as a witness. If they get a different story from what the plaintiff's expert witness says, they may call their witness to create some doubt. Then the judge or jury must decide which expert witness is more credible in their testimony.

If you are hired, you'll be asked to create a written report to be presented to the court. The report should include the facts of the case, cause-and-effect, and details establishing and explaining your opinion.

The report should include a cover letter describing the objectives of the report, a bibliography, a list of other professionals consulted, and a list of discovery items reviewed that led to the opinion.

Expert witnesses are compensated either by a retainer paid up front and a fee based on court appearance and time or by an hourly flat rate including court time and preparation. You should present your bill to the attorney who hires you. Do not include it in your written report to the court.

The length of time a preparation takes depends on the case. As an expert witness, you'll have access to all the documentation and information made available to the attorney during the discovery, and you should carefully review it before your court appearance.

"I've had multiple boxes delivered for some cases or received a large packet in my mail box in other cases. It all depends on the case and the circumstances of the case," she says.

After the written report has been submitted and reviewed by both sides in the case**,** there are two ways that an expert delivers his or her opinion, Kizziar points out:

• **A deposition** is less formal than courtroom testimony and is taken in the presence of attorneys from both sides and a court reporter, and, in some cases, a video camera. It is considered to be a discovery device that the opposing side will use to learn what information you will be providing during the trial. This testimony is given under oath and may be reviewed by the judge and jury during the trial.

You'll be given a transcript of your deposition and required to review and sign it, attesting to its accuracy.

• **Courtroom testimony** is given under oath before the judge and jury in support of the written report. It is acceptable to reference the written report to clarify information, but the expert can't just read the report, Kizziar adds.

When there are expert witnesses on both sides, the case may involve a "battle of experts," she says. That's why it is critical to analyze every detail of the other side's report and to make sure the attorney on your side is fully apprised of the nuances of your opinion, Kizziar adds.

Each expert witness will be called on to justify his or her areas of expertise against those of the opposing expert.

When you are called on to testify, it's important to be perceived as knowledgeable and self-assured without appearing cocky. Orient your testimony toward the jury and speak in easily understood terms, Kizziar says.

Keep in mind that the jury members are not

clinicians and explain any professional jargon you use in easily understood language, she says.

Avoid being argumentative with the other side's attorney when he or she challenges your opinion during cross-examination, she adds. ■

Program helps students cope with college life

Advocates make referrals for appropriate services

Drawing on its 30 years of experience in employee assistance programs, CIGNA Behavioral Health has begun a new Student Assistance Program to help students adjust to life on a college campus and cope with common behavioral health concerns such as stress, depression, suicide, and alcohol and substance abuse.

"College is a stressful time for students. It's the first time they're away from home without their support system. They have to learn in a whole new way and are responsible for more things than ever before. We saw a need for services," says **Jodi Aaronson Prohofsky**, PhD, LMFT, senior vice president of clinical operations.

CIGNA Behavioral Health, based in Eden Prarie, MN, contracts with colleges to provide

the student assistance program and is the only national full-service vendor of student assistance programs in the United States.

Although most college and universities offer counseling programs through their student health centers, they aren't equipped to deal with all of the emotional issues that face today's college students, she adds.

"For the past few years, we've seen a lot of stories in the press about suicide among college students. As an organization, we are clearly focused on preventative health and well-being. We researched the industry to see what was offered and found that no one was offering these particular services," Prohofsky says.

The first program went into effect April 1 and covers 5,000 students at New Mexico Highlands University and Luna Community College, both in Las Vegas, NM.

"Students face a myriad of emotional challenges that can impact academic performances. Bringing CIGNA Behavioral Health's program on campus ensures that we can provide the highest level of service to help our students manage their emotional health," says **Judy Cordova**, dean of students at New Mexico Highlands University.

All students enrolled in a participating university receive a toll-free number that they can call twenty-four hours a day, seven days a week to discuss any kind of issue.

The program is staffed by behavioral health managers called personal advocates who are bachelors- or masters-level paraprofessionals with degrees in psychology or social services and licensed behavioral care professionals who are available to take crisis calls.

Threats to mental well-being of college students

- **Depression:** At colleges nationwide, large percentages of college students are feeling overwhelmed, sad, hopeless, and so depressed that they are unable to function. According to a recent national college health survey, 10% of college students have been diagnosed with depression, including 13% of college women.
- **Anxiety disorders:** In 2000, almost 7% of college students reported experiencing anxiety disorders within the previous year. Women are five times as likely to have anxiety disorders.
- **Eating disorders:** The highest rates in eating disorders occur in college women. Overall, as many as 10 million women and 1 million men suffer from eating disorders.
- **Suicide:** According to a study in 1998, suicide was the third leading cause of death for those 15-24, and the second leading killer in the college population.
- **Frequent mental distress:** According to the Centers for Disease Control and Prevention, 7.8% of men and 12.3% of women 18-24 report frequent mental distress — a key indicator for depression and other mental disorders.
- **Overwhelming stress:** According to a recent University of California – Los Angeles survey, more than 30% of college freshman report feeling overwhelmed a great deal of the time. About 38% of college women report feeling frequently overwhelmed.

Source: CIGNA Behavioral Health and the National Mental Health Association (nmha.org).

"Students with behavioral health or personal problems no longer have to go through their student health center, which may have a long wait for service and is likely to be closed at 2 a.m. when a problem arises," Prohofsky says.

In the first days of the program, the personal advocates fielded questions that ranged from depression and anxiety to eating disorders and relationship issues.

The personal advocates are trained to help students connect with the appropriate resources to help with their individual needs. CIGNA Behavioral Health has a nationwide network of 45,000 providers offering clinical and nonclinical services.

The program includes a staff of licensed behavioral health clinicians who can handle crisis calls as well as referrals for face-to-face counseling with local clinicians.

Nonclinical resources include tutors, legal assistance, financial consultants, help for crime victims, AIDS support, gay/lesbian programs, support for single parents, child abuse information, and information on women's issues.

"We are drawing on the resources we have developed for our employee assistance programs," Prohofsky says.

For instance, a student who gets a speeding ticket and doesn't want to tell his or her parents may ask to be connected to an attorney near the college to help them decide what to do.

Most of the personal advocates have experience in social work or psychology.

They go through an eight-week training program that includes everything from how to provide excellent customer service to what kind of service callers would expect when they call a toll-free number. They learn what questions to ask the caller and how to identify someone who is in crisis.

The personal advocates don't provide counseling but identify what the issues are and refer callers to the appropriate services.

"When a personal advocate takes a call, the goal is to get an understanding of the caller's individual issues and to make the most appropriate referral," Prohofsky says.

If the student needs to talk to someone on the telephone immediately, the personal advocate can refer him or her to a clinician who is available. If the personal advocate determines that the situation is a crisis, the call is immediately transferred to a clinician.

The personal advocates can refer students to a library of educational material that includes tip sheets on developing good study skills and other advice.

Every student who is seen by a student assistance counselor is contacted two weeks after the last session for feedback to determine if the services are satisfactory and address any additional concerns or situations. ■

Insurer to pay physicians for e-mail consultations

Project returns physicians to disease management

In an effort to ensure that chronically ill members get the most effective and efficient health care services, BlueCross BlueShield of Tennessee has developed a pilot project to pay physicians for e-mail consultations, telephone calls, and group visits with members with diabetes, hypertension, or congestive heart failure.

"We're developing a disease management program that puts the doctor back in the middle of the game," says **Steve Coulter**, MD, senior vice president and chief medical officer for the Chattanooga-based insurer.

The pilot project, which started May 1, involves about 1,300 physicians, representing 10% of the health plan's physician network and will be tested against the company's traditional integrated disease management programs.

About 3,000 patients have been selected to participate in the program. They will have the option of continuing in the standard disease management program or participating in the physician-centered program.

The company will pay physicians $25 for an e-mail, $25 for a telephone call, and $20 per person for a group visit with chronically ill patients who choose to participate in the program. Patients do not have a copay for any of those services, unlike with office visits.

The company also may reimburse for services provided by nurse clinicians, such as diabetic nurses who work in the physician office.

"The whole goal of an incentive program is to try to get someone to do something you want them to do," he says.

Physicians would like to spend more time giving advice and assistance to help patients manage their chronic illnesses, but most simply don't

have the time to provide a service for which they're not reimbursed, Coulter points out.

"The purpose of a good disease management program is to empower the patient with the knowledge of the disease, the tools to help them manage the disease, and a support structure to facilitate the process. We're not trying to intrude ourselves into the doctor-patient relationship. One of the problems with disease management programs is that people perceive them as being too much meddling by the insurance company," he says.

The insurer is providing physicians in the pilot project with an interactive e-mail tool by RelayHealth Corporation, an Emeryville, CA-based provider of on-line physician-patient communication services.

The e-mail program prompts the patient to give the right kind of information so the physician can give the right advice.

Physicians also may bill for telephone calls and for group visits for the purpose of educating patients about their disease. A few physicians have tried group visits for their chronically ill patients, Coulter says.

The aim of the pilot project is to test ways to realign incentives for the players in the health care system, Coulter says.

"All of the players in the health care system, whether they're patients, doctors, employers, payer, or hospital, have the same fundamental set of values. We just need to get the incentives to line up with those values," he adds.

Fee-for-service medicine encourages physicians to do more complex procedures, while the capitation system creates incentives for physicians to do too little, Coulter says. "These systems have created an inherent mistrust that is part of the overall rebellion against managed care," he adds.

The idea for the project came from a brainstorming seminar the insurer held for representatives of large employers, hospital administrators, physicians, and academicians at Vanderbilt University in Nashville, TN.

The objective was to develop a pilot program that would better align the incentives of patients, physicians, and insurers.

"The providers made the point that our current system just doesn't create incentives to practice quality medicine. It creates barriers. We do pay for coronary bypass surgery, but we don't pay for low-cost interventions like phone calls and e-mails," Coulter says.

Low-cost interventions produce more value for the dollar, particularly with people with an ongoing chronic disease who need guidance and advice on a regular basis, Coulter says.

"At this point, we're offering incentives to try to move the barriers. Next, we plan to attach incentives to program metrics," Coulter says. ■

90 million adults with poor reading skills are at risk

Outcomes, health care literacy of patients linked

Adults with lower than average reading skills are less likely than other Americans to get potentially life-saving screening tests, be vaccinated for flu and pneumonia, and take their children for well-child physician visits, according to a report by the federal Agency for Healthcare Research and Quality (AHRQ).

Another report, by the Institute of Medicine concludes that low health literacy — the ability to read, understand, and act on health information — costs the health care system more than $58 billion annually.

The AHRQ study also found that people with lower literacy skills are likely to have difficulty understanding informed consent forms and comprehending their children's diagnoses and medication instructions. They are less likely than other Americans to be knowledgeable about the health effects of smoking, diabetes, asthma, AIDS, and postoperative care.

The Partnership for Clear Health Communication, a national coalition of organizations working for solutions to low health literacy, has developed an action agenda identifying a number of recommendations:

- Educating patients and providers about health literacy.
- Developing and applying practical solutions to improve patient-provider communication.
- Conducting nationally coordinated research to further define the health literacy issue and evaluation solutions.
- Increasing support for health literacy policy and funding.

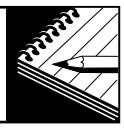
The organization's first initiative is Ask Me 3, which presents three simple questions that patients should ask providers in every health care setting. They are: What is my main problem? What do I

need to do? Why is it important for me to do this?

The American Medical Association Foundation plans to convene a summit meeting in 2005 to address improving health literacy in clinical settings.

For more details on health care literacy, see the following web sites: www.AskMe3.org; www.amafoundation.org; www.ahrq.gov. ■

GUEST COLUMN



Clear, appropriate CM documentation essential

Be especially careful when case is terminated

By **Diane L. Huber**, PhD, RN, FAAN, CNAA, BC
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Documentation is a valuable communication tool throughout the case management process, providing an accurate record of the assessment, care plan, and execution of treatment and services. Through systematic collection of information about the service experience, the end results of care can be evaluated.

When case management services are terminated, for whatever reason, careful documentation also is essential. The documentation completed at termination must be factual, clinical, and devoid of any personal opinion or judgment. Case managers must take pains to ensure their documentation is objective and does not create a perception that would violate their role as advocates on behalf of the patient or client receiving services or have the appearance of bias.

The need for clear and careful documentation is underscored by the current definition (2002) of case management from the Case Management Society of America (CMSA). The CMSA describes case management as "a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes."

The key words of "assessment, planning, facilitation, and advocacy" are the guiding principles for documentation, which begins when the relationship with the patient is established and continues through the course of treatment. Some case management providers may find it helpful to streamline documentation, even providing standardized scripts to guide case managers in the process. This might include, for example, a letter of introduction that clearly specifies the case manager's role and relationship with the patient.

The rule of thumb is that documentation is just for the facts: The assessment is detailed, the plan is discussed, and what occurred is noted. The case manager's own hunches and speculations generally should not be included. For example, phrases such as "the patient doesn't want to work," or "the patient is uncooperative," do not belong in the documentation. Rather, the documentation content should consist of quoted statements and observable actions. An unbiased, factual assessment, with the suspension of judgment, should allow anyone to read the case documentation and understand exactly what transpired.

When case management is terminated, documentation should include the reasons why the relationship ended. The patient, the provider, or the payer may trigger the termination of services. Eight typical reasons for terminations are:

- Death.
- Relocation out of the service area.
- Patient cannot be located.
- The patient is not available for services for more than 90 days (e.g. institutionalization).
- The patient is no longer in need of services.
- Patient refuses further services.
- Patient requests termination.
- Patient refuses to cooperate with case manager in needed services.

Among these termination scenarios, some of the trickiest — particularly from the perspective of the documentation — are when the provider terminates because the patient is uncooperative or unpleasant; the patient refuses to comply with treatment; or there is an incident involving actual or threatened violence.

The case manager must guard against allegations of abandonment through careful assessment and documentation. Once services are begun with a patient, there is a duty to provide care. Once the relationship is started, any changes (such as the payer refuses to pay for more care), need to be noted. The case manager also must document efforts to assess whether the patient needs further services, and if so, what was done to ensure the patient will not suffer harm.

The documentation needs to reflect termination with reasonable written notice and with a plan for referral or other measures to meet the patient's needs for care to avoid harm. A team care conference and careful discharge plan that is documented in detail are recommended.

Despite the emotional element in these termination scenarios, case managers must redouble their efforts to ensure documentation states the facts and only the facts. A good recipe for case management termination includes the following:

- Assessment of no benefit/no need.
- Documentation of discussion with patient.
- Written notice, delivered.
- Documentation of no further action needed.

All of the above is recorded in the patient's record.

Careful documentation is far more than just the necessary paperwork. It is a complete, accurate, and factual account of the case from beginning to end. Strategies include careful and precise choice of words and full and complete recounting of events and outcomes.

The challenge for the case manager is to suspend emotional reactions and the tendency to ascribe blame, particularly when the relationship with the patient is difficult or uncomfortable. The reward, however, is to know that their case management responsibilities were discharged professionally, appropriately, and in keeping with their essential roles as advocates. This also is the best recipe for ethical and legal safety.

Diane Huber, PhD, RN, FAAN, CNAA, BC, is a professor at the University of Iowa (UI) College of Nursing, teaching case management courses. She also is an investigator at the UI Center for Addictions Research, Institute for Strengthening Communities. Huber has a secondary appointment at the UI College of Public Health (Department of Health Management and Policy). She is chair of the Commission for Case Manager Certification (CCMC), which has awarded the certified case manager (CCM) credential to more than 26,000 case management professionals since 1992. The CCMC is the first certifying body for case management professionals to be 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.ccmcertification.org. ■

NEWS BRIEFS

Michigan hospitals track bioterror

Nine Michigan hospitals are participating in a statewide surveillance pilot program to track potential bioterrorist attacks, infectious disease outbreaks, and other public health emergencies. The syndromic surveillance system focuses on assembling information as close to real time as possible from the hospitals, which would allow for early detection and intervention.

If the system detects an outbreak or emergency, an automated response will be sent to epidemiologists at the Michigan Department of Community Health (MDCH), which then will analyze the findings and investigate further.

The Michigan Health & Hospital Association is helping coordinate the effort, which will be expanded later this year to include more hospitals. The system is guided by a steering committee made up of representatives of MDCH, local health departments, regional hospital bioterrorism coordinators, medical directors, and participating facilities.

The program is funded through a cooperative agreement with the National Bioterrorism Hospital Preparedness Program of the U.S. Department of Health and Human Services' Health Resources and Services Administration, and the Center for Disease Control and Prevention. For more information, go to: www. hrsa.gov/bioterrorism/. ▼

COMING IN FUTURE MONTHS

- Providing care for patients from other cultures
- Proving the value of case management services
- Integrating social work with case management
- Specialty case management programs

Nursing organization adopts 2004 platforms

The American Organization of Nurse Executives (AONE) in Washington, DC, a subsidiary of the American Hospital Association, has unveiled its policy platforms. The major policies are:

• **Foreign Nurse Recruitment**

AONE supports the lawful entry of nurses from foreign countries to work in the United States and its territories provided they meet all federal qualifications for entry and practice.

It is incumbent upon institutions that recruit foreign nurses to foster an environment that is culturally sensitive and supportive as these nurses are assimilated into the American health care system.

• **Mandatory Overtime**

It is the view of AONE that mandatory overtime is the staffing vehicle of last resort, limited to crisis situations that would put patients in danger of not receiving the basic requirements of the safe care that they require.

• **Mandated Staffing Ratios**

AONE does not support mandated nurse-staffing ratios. Mandatory nurse staffing ratios only will serve to increase stress on a health care system that is overburdened by an escalating national and international shortage of registered professional nurses and has the potential to create a greater risk to public safety.

The AONE policy statement can be found on its web site (www.hospitalconnect.com). ■

CE questions

26. Premera Blue Cross estimates that its case management program achieved what amount of savings in a six-month period during 2003.
    A. $1.5 million
    B. $12.3 million
    C. $16.7 million
    D. $10.4 million

27. Case managers who want to become expert witnesses should appear for both the plaintiff and the defense to avoid being thought of as a hired gun whose testimony is for sale, according to B.K. Kizziar.
    A. True
    B. False

28. What percentage of college freshmen at UCLA report feeling overwhelmingly stressed, according to CIGNA Behavioral Health statistics?
    A. 30%
    B. 15%
    C. 10%
    D. 25%

29. BlueCross BlueShield of Tennessee has developed a pilot project to reimburse physicians for telephone calls, e-mails, and group visits. What are the rates?
    A. $50 for each
    B. $20 for phone calls, $15 for e-mails, $20 per person for group visits
    C. $30 for each
    D. $25 for e-mail, $25 for phone calls, $20 per person for group visits

30. According to Diane L. Huber, the four guiding principals for documentation are:
    A. assessment, planning, advocacy, outcomes
    B. planning, advocacy, facilitation, outcomes
    C. assessment, planning, facilitation, advocacy
    D. planning, communication, advocacy, outcomes

Answers: 26. B; 27. A; 28. A; 29. D; 30. C.

CE objectives

After reading this issue, continuing education participants will be able to:

1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how those issues affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities. ■