Case Management ADVISOR™

Covering Case Management Across The Entire Care Continuum

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IN THIS ISSUE

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With wide variety of organizations to join, which do you choose?

Some fear that case managers are losing their voice

Case managers have a lot of choices when it comes to what professional organizations to join and which certifications to pursue. There are a wide variety of organizations on the local, state, and national levels, along with several case management certifications.

Some movers and shakers in the case management field are concerned that the proliferation of specialty organizations will dilute the power of case managers to gain acceptance as a profession among other health care providers and the public and to have an influence on the direction the health care field is taking.

"Everybody seems to be going off into special interest areas, and we are losing some of the credibility and strength that comes in numbers. As we try to move forward into professionalizing the role of the case manager, this fragmentation could hold us back," says **B.K. Kizziar**, RNC, CCM, CLP, owner of B.K. & Associates, a Southlake, TX, case management consulting firm.

Some leaders in the case management field believe that if you're doing case management, you're basically doing the same thing as your colleagues in other venues, whether you work for an occupational health company, a rehabilitation facility, a managed care company, a hospital, or have your own consulting firm.

"Case management principles of practice don't change with the setting. There are a lot of different case managers with varied educational backgrounds and practice settings who, fundamentally, are doing the same thing while working with their clients in different settings. They're still case managers, no matter who signs their paycheck, and based upon that, their clients are the individuals for whom they advocate," says **Connie Commander**, RN, CCM, ABDA, CPUR, owner and president of Commander's Premier Consulting Corp., and national president-elect of the Case Management Society of America (CMSA).

But case managers who practice in a particular specialty disagree, feeling

that they need an organization that meets their special needs, says **Greg Cunningham**, chief executive officer of the Little Rock, AR-based American Case Management Association, an organization for hospital and health system-based case managers.

"Hospital case managers believe their practice settings, issues, and needs for networking and education are distinct. That's not to say they couldn't learn from case managers in other practice settings, but they wanted an organization that is dedicated to their needs," he explains.

Belonging to a specialty organization doesn't preclude belonging to a broader organization, such as CMSA, but it does give case managers an opportunity to network with and be educated by people who do the same thing, points out **Shelly Martin**, RN, BSN, MHSA, CPHQ, CCM, CMCN, who is a member of CMSA as well as serving as president of the American Association of Managed Care Nurses (AAMCN), headquartered in Glen Allen, VA.

"There are so many different jobs under the broad umbrella of case management that one organization can't provide everything that every case manager needs. That's what the specialty organizations provide," she adds.

Regardless of the setting in which they practice and the organizations to which they belong, case managers need to join together and market themselves and their profession, Kizziar says.

"In general, the public has no idea of what case management is or what a case manager could do for them unless they've been given an opportunity to utilize our services. While specializing in a particular area is certainly important if that is your calling, case managers need to remember the foundation and basis of our profession and to speak as one voice in educating the public," she adds.

Case managers have long struggled to get the public to understand exactly what their job entails, Commander points out.

"If we can't agree among ourselves what we do, how can we get the public to understand?" she asks, adding that CMSA has tried to address the needs of all case managers with varied educational backgrounds and different work environments.

Commander tells of attending a conference of buyers of health care, intermediaries, and consumers where the focus was on health maintenance.

"No one understood what a case manager was. Some people thought the case manager was the person you called to verify the insurance. Others thought our jobs were more like risk managers. If we want to have any kind of influence, case managers must unite and speak with one voice. The more we splinter off into separate groups, the more our voice will be diluted," Commander says.

Kizziar and **Mindy Owen**, RN, CRRN, CCM, chair of the Commission for Case Manager Certification, expressed concern that the proliferation of specialty organizations will weaken case managers' voices in much the same way it happened with nurses.

"We in the nursing world have shot ourselves in the foot for years. We have so many specialty organizations in nursing that we have lost our voice. I believe that had we kept together and had one strong voice, the health care system would not be in the situation we're in today," she notes.

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Editorial Questions

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

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Case managers provide a valuable service that other health care professionals can't provide, Owen says.

"Sometimes we lose sight of the fact that, in addition to advocating for individuals, our role is to advocate in terms of the health care system. We don't do ourselves, our patients, or the health care system a service when we fragment ourselves, losing focus on our commonalities and our ability to influence the delivery of health care," she adds.

But case managers who specialize want to be able to network with people who do the same thing and become proficient in their specialty in addition to learning about case management in general, representatives of the specialty organizations point out.

"CMSA has great conferences and a phenomenal learning library, but what's missing is a significant amount of information on managed care. The CCM exam is one of the hardest I've ever taken. It's an excellent credential, but there's very little managed care information on it," Martin says.

A core group of hospital case managers started the American Case Management Association in 1999, Cunningham says.

"ACM's six-year average growth rate of 25% annually seems to validate that distinct practice setting issues can be met by an organization solely devoted to their unique needs. However, ACMA is rooted in a collaborative philosophy and has, with CMSA supported the consolidation of previously separate National Case Management Week dates," Cunningham says.

The collaborative decision indicates that ACMA has a willingness to work together as a "common voice" for case managers, he says.

"Collective influence is not decided by the solidarity of everyone having the same credential or the same association membership. It is determined by professionals who are committed to what is in the best interest of case management practice deciding to work together," he says.

The ACMA concentrates on the practice of hospital case management rather than a generic case management practice. It has developed a definition for hospital case management, standards of practice, and a code of ethics.

"We scientifically validated through a practice analysis a distinct body of knowledge for certification, the Accredited Case Manager [ACM] for hospital-based and social work case managers. We focused our educational efforts on what is relevant to the hospital practice setting," he adds.

The AAMCN was formed in part to combat the negative perception of managed care and the misunderstanding about the role of nurses who work in the managed care setting, Martin says.

"In the past, managed care nursing hasn't been recognized as a specialty. There wasn't a lot of education and networking available between managed care professionals. The organization offers a huge opportunity to those of us in the field," Martin says.

Multiple memberships reap many benefits

Belonging to multiple professional organizations gives case managers the ability to share information and get information from a wide variety of people in other professional fields as well as the case management field, Commander says.

"We never want to stop people from joining organizations that represent their special interests, but we would encourage them to also participate with CMSA to share information and join together to educate the public on what benefits case managers can bring to the table. Having one all-encompassing organization will unite and strengthen our voice," she adds.

Kizziar is active in the Dallas-Ft. Worth chapter CMSA as well as two Texas case management organizations — the West Texas Society for Case Management and the Case Management Society of South Texas. The organizations each have about 300 members and neither organization is affiliated with CMSA.

"These are grass-roots organizations that pull together case managers from all areas of practice to network and to offer one another support," she reports.

Kizziar worked with the Dallas-Ft. Worth chapter of CMSA to bring together leaders from nine other chapters across the country and spend two and a half days with a facilitator looking at the issues and challenges that confront case managers every day.

"The grass-roots organizations are great, but we also need a centralized organization that will speak for all case managers. Case management principles of practice do not change, regardless of the environment in which the case manager practices. They may be used differently, but the principles never change," she says.

What can the individual case manager do to ensure that case management continues to have a strong voice in the health care field?

"Case managers need to understand the issues that face their practice and consumers as well as what professional resources are available to them and the publics they serve. They should be willing to go to a variety of meetings to learn and bring forward issues involving case management and the public. This usually takes a commitment to get involved in an organization at the local, state, and national level," Owen says. ■

Program screens members for postpartum depression

Info, follow-up calls, referrals prevent other problems

Members of Blue Cross Blue Shield of Missouri's Postpartum Depression Screening Program consistently give the St. Louis-based health plan patient satisfaction scores in the 90th percentile.

Since the program was launched in November 2001, more than 25,000 women have been screened for postpartum depression and received information and resources about the illness and treatment options.

Postpartum depression is common and affects between 10% and 13% of all women who have given birth or experienced an adverse obstetrical outcome to a pregnancy, but treatment for women suffering from the condition often is underutilized, reports **Pat Jones**, RN, BSN, project manager for the postpartum depression program for Blue Cross Blue Shield of Missouri (BCBSMo).

"Postpartum depression doesn't affect a huge number of members, but can have devastating effects on the mother and those around her. Even though the volume of cases is small, we felt we had the tools and the ability to develop a program that could make a difference in the lives of our members, says **Kathleen McDarby**, RN, MPH, senior health service analyst for BCBSMo.

If left untreated, the condition can last for at least a year. Treatment includes a combination of medication, talk treatment, and self-help strategies. With treatment, the symptoms improve more quickly. Women who have postpartum depression have trouble with daily activities of self-care and child care. Postpartum depression potentially can affect the infant, other children in the family, and the couple's relationship.

The health plan has developed an algorithm to pull medical claims to identify women who qualify for the program. The process is performed on a weekly basis.

"We examine claims from every woman with any type of medical claim that has an obstetric background, whether it's a normal birth, a premature birth, a stillbirth, or any other condition. This makes our program unique because many programs do not include women who have had an adverse outcome to the pregnancy or a premature infant," McDarby says.

Members who are identified from claims data receive a letter explaining the postpartum depression program, a brochure listing the causes and symptoms of the condition, with a section on grief and loss, and the Maternal Mental Health Survey, a 10-question screening tool.

About 33% of the women who receive the survey completed it and sent it back in the self-addressed, postage-free envelope supplied with the survey.

An outreach specialist scores the surveys and gives the names of members whose scores are positive to Jones, who contacts the members by telephone.

Members who screen negative for postpartum depression also receive a letter informing them that their score is normal at this time, but should they develop any of the listed signs and symptoms, they should contact their medical provider promptly.

"We thank them for participating and remind them not to ignore the symptoms if they do occur in the future," Jones says.

"There is no formal script for my outreach calls. Instead, each member is approached as an unique individual. The questions I ask are determined by how they answer the survey questions and my general impression from talking with them. However, with every member, I assess for their own safety and the safety of their child," she explains.

When she calls a member who screened positive for postpartum depression, Jones has a list of three behavioral health providers at hand. The providers have been contacted by the outreach specialist to make sure they have appointment slots available.

If Jones' assessment determines that the members need professional help, she encourages them to accept a referral to a behavioral health provider.

"I give them options to choose from a list of behavioral health providers so they are involved in the decision-making process," she adds.

About 40% to 50% of the members choose to go back to an established provider, either their primary

care physician or their obstetrician, because they feel more comfortable with a known provider, Jones adds.

"Some members recognize the extent of their depression and will accept a referral. Very few of these members are already in treatment, so it's usually a starting point for them," she says.

Jones asks the members to call her back after they make an appointment, and many of them do. She makes a follow-up call three months later to see how the treatment is going and to see if the member needs more referrals for behavioral health services.

"Once I've made that three-month call and the member is not in need of further behavioral health services, I consider them graduated from the program. I leave the member with the knowledge that they can call me if they feel like they need further assistance with referrals," Jones says.

In most cases, within three to six months of treatment, the member's symptoms have lessened or may have resolved.

"Most members will remain in treatment for six to 12 months. At that point, most members have had their medication titrated down to a lower dose and therapy visits are less frequent. In general, postpartum depression is usually easily resolved when identified and treated early," Jones says.

The postpartum depression program was developed by Blue Cross Blue Shield of Missouri's quality management department in collaboration with behavioral health.

They worked with Blue Cross Blue Shield of Missouri's internal communications and graphics department to produce the brochure.

The content of the brochure was reviewed by the plan's quality improvement peer review panel, which includes network physicians, obstetrician/gynecologist, psychiatrists, family practitioners, and pediatricians.

"We received positive feedback from all of them. The psychiatrists were particularly complimentary about the brochure," McDarby says.

The program has been accredited under disease management standards for URAC. It's been so successful that it's been expanded to other programs and Blue Cross Blue Shield plans in other states. ■

Program helps young asthmatics control disease

Program combines basketball, disease management

In the first six months of Keystone Mercy Health Plan's Healthy Hoops program, which combines basketball and asthma management, the percentage of children in the program with an emergency department visit for asthma fell 26%, the percentage of children with a hospital admission decreased by 8%, and nighttime awakenings decreased by 70% among program participants.

The program, which targets Keystone Mercy's Medicaid members and other low-income children with asthma, was begun in 2003 after the health plan identified a high incidence of asthma among children in West Philadelphia.

Healthy Hoops is the brainchild of the health plan's president and chief executive officer, Daniel J. Hilferty, who was looking for innovative ways to reach out to an often difficult-to-manage chronic disease population.

The program uses a four-part strategy — outreach, program events, asthma disease management, and member incentives — to educate young members and their parents on asthma control.

Participants who sign up for the program receive a basketball. If they continue the program, they earn a chance to participate in the Healthy Hoops Fall Challenge.

The program has since been expanded to other areas of Philadelphia, Chester Township, PA, and South Carolina through the health plan's sister company, Select Health of South Carolina Inc. More than 1,000 children have participated in the program since its inception.

When the program began, Keystone Mercy targeted three zip codes where there were high rates of asthma among the plan's members and in the community at large.

Initially, the health plan enrolled members by sending a brochure and enrollment form to families with children ages 7 through 15 with asthma in the targeted area. Now in addition to offering the program to members, the plan works with school nurses, coaches, and gymnastics teachers, and community and health care organizations to help identify children with asthma.

Keystone Mercy case managers make follow-up phone calls to everyone who receives the brochure, to encourage them to join the program and to answer any questions about the program.

"The community has embraced it in so many different ways. The school nurses, school teachers, gymnastic teachers, and basketball coaches

are all involved and have helped make it grow," says **Maria Pajil Battle**, senior VP of public affairs and marketing for Keystone Mercy.

To participate in the program, the children must undergo a comprehensive physical examination and a spirometry screening to test lung capacity. Their parents must attend a workshop to teach them how to care for a child with asthma, how to identify asthma triggers, environmental issues that affect asthma, and proper asthma management.

"Our goal was to positively change their behavior and to address medication issues. Many of these children were not using preventative medicine but were relying on rescue medications," Battle says.

The parents' workshop includes one-on-one coaching by an asthma educator who helps develop a treatment plan for the children and educates the parents on medication and equipment.

"The parents were really enlightened. They didn't know how to clean a nebulizer or how to operate a peak flow meter," Battle says.

The six-month program opens each spring with a Healthy Hoops kick-off where participants register for the health screenings that are held throughout the targeted neighborhoods. Participants receive a basketball when they complete the health screening.

Professional basketball coaches and celebrity players work with the young participants on basketball drills during the kick-off event. The event was held in 2005 at an entertainment complex. During the kick-off festivities, parents and children are provided with information about asthma, weight management, and the prevention of cardiovascular diseases.

The program culminates in a full-day basketball clinic, the Healthy Hoops Challenge, where participants undergo another round of spirometry screenings to ensure that they are healthy enough to participate in the day's activities and to determine if they have been managing their asthma.

The Healthy Hoops Challenge features coaching sessions and basketball drills by sports figures and coaches, live entertainment, and workshops for parents.

In the second year of the program, the health plan added a professional education component, to teach area sports coaches and physical education teachers in the Philadelphia public schools about juvenile asthma and the Healthy Hoops program.

"Whether they play basketball, football, or participate in other athletic programs, children with asthma often have to sit on the sidelines. Some of the coaches were telling them to use someone else's inhaler. They didn't realize that the children needed medication tailored to their specific needs," Battle says. The coaches have become some of the program's biggest supporters, spreading the word throughout the community, she adds.

"Children in the program have become peer educators. They teach the young kids how to use the peak flow meters and measure their lung capacity," Battle says.

The health plan provides asthma education training to school nurses, Keystone Mercy Health Plan nurses, provider office nurses, and Pennsylvania Department of Health nurses. The training session, which provides asthma facts, prevention skills, and updated management techniques, was designed to provide continuing education units for participants.

The program was developed by the Keystone Mercy Health Plan and the Healthy Hoops Coalition, which includes doctors, nurses, asthma educators, representatives of community organizations and health departments, and nationally recognized basketball personalities. ■

Not every injury/illness requires time off

Panel recommends different approach to time off

Occupational health professionals are constantly looking for ways to improve return to work (RTW) for injured or ill employees, but there has been little in the way of research into what makes disability leave, RTW, and stay at work (SAW) plans work — or fail.

A panel of occupational health experts has taken a look at the RTW/SAW process and found that, in many cases, the way disability, RTW, and SAW are handled is not always in the patient's best interest.

"Helping people minimize the disruptive impact a disability has on their lives is a team sport, and we're not playing like it's a team sport," says **Jennifer Christian**, MD, MPH, an occupational medicine physician who served as chair of the Stay and Work and Return to Work Committee for the American College of Occupational and Environmental Medicine (ACOEM), which late last year issued a report, "Preventing Needless Work Disability by Helping People Stay Employed."

What Christian and her colleagues found is that "the disability system typically turns an

impersonal face toward a person whose life has been disrupted and who may need guidance in managing a new life situation." The result of this is that in many cases, an injury or illness that could have been only of minimal disruption to the person's life and livelihood instead is turned into a major disability that changes their lives and takes away their ability to work.

With the aging of the American work force and the rising burden of chronic disease, the impact on workers' function also is rising. Episodes of prolonged disability due to common conditions such as depression and low back pain are becoming more common.

Christian says that while statistics show the incidence of work-related injuries and illnesses has been falling steadily for the last several decades, the length of disability following work-related injury has been climbing, as have the number of medical services and their costs. Paradoxically, employers are paying for more — and more expensive — medical services, but people, nevertheless, are losing more time from work for medical reasons.

"The focus of our report is on the large number of people who end up with prolonged or permanent absence from work due to medical conditions that normally would cause only a few days of work absence," says Christian.

"Many of those who end up receiving long-term disability benefits of one sort or another have conditions that began as common everyday problems like sprains and strains of the low back, neck, shoulder, knee, and wrist, or depression and anxiety."

The ACOEM committee set about to test their shared belief that a good deal of work disability can be prevented or reduced by finding new ways of handling important nonmedical factors that are fueling its growth.

"Why do some people who develop common everyday problems like backache, wrist pain, depression, fatigue, and aging have trouble staying at work or returning to work?" Christian says the committee set out to answer that question. "How can employers and insurers work more effectively with health care providers to reduce the disruptive impact of injury, illness, and age on people's daily lives and work, and help them remain fully engaged in society as long as possible?"

Some nonmedical aspects of the SAW/RTW process, Christian and her colleagues say, are causing harm to the health and well-being of the same people that these systems were designed to protect, as well as harm to their families, employers, communities, and society as a whole.

"We see how often participation in the disability benefits system is counterproductive in our patients' lives, some of whom are particularly susceptible," she says. "The disability system typically turns an impersonal face towards a person whose life has been disrupted and who may need guidance in managing a new life situation. We also see how often the SAW/RTW process is both openly and surreptitiously distorted by other interests."

As a result, Christian says the disability benefits system too often:

- fails to provide nonfinancial support to people who need help because their life has been disrupted by illness or injury;
- fails to help people adapt or understand the course of their illness and their future life options, and defeats what would otherwise be a successful medical result;
- wastes resources on people who do not need them;
- causes people to refocus their lives and adopt a new identity as disabled people, resulting in society's loss of potentially productive members.

"In some ways, it was two kinds of fundamental ideas — that disability is often preventable, and the corollary that a lot of today's disability is not medically required," says Christian.

The cost to employees and employers is substantial, Christian says — the employer loses the employee's contributions as a worker, the employee loses the fulfillment of working.

Many times, occupational medicine physicians have a clear picture of how often the amount of time an injured person is actually off work is out of proportion to how much time he or she *needs* to be off, Christian says.

"Look at the difference between a self-employed person and someone who is not self-employed," says Christian. While an employee with a large company behind him or her can take the maximum amount of time off when sick or injured, the self-employed worker with the same disability can't afford as much downtime, and is back to work much more quickly.

The group made four general recommendations for improving the system, a process it says has to start with a dialogue between ACOEM and stakeholders in workers' compensation and the nowork-related disability benefits system, including employers, unions, workers, the insurance industry, policy-makers, health care, and lawyers.

Unless complete work avoidance is medically required for healing or for protection of the worker, co-workers, or the public, Christian says, case

managers, occupational health nurses, physicians, and the ill or injured employees should be looking for ways to prevent or reduce absence from work.

"Expecting and allowing people to contribute what they can at work and keeping them active as productive members of society is good for them, and for us all," she says.

The ACOEM committee recommends everyone on the RTW "team" stop assuming that absence from work is always medically required. Nonmedical causes can contribute to "discretionary" and unnecessary disability; the committee proposes that employer-sponsored, on-the-job recovery reduces the lure of discretionary disability. Removing administrative delays and bureaucracy, and educating employers about taking a stronger role in determining SAW/RTW results also can help.

• Address behavioral and circumstantial realities that create and prolong work disability.

Scientific research shows that workplace factors such as job dissatisfaction or poor job fit have a powerful effect on disability outcomes, Christian says.

The occupational health nurse should become comfortable with the idea of intervening in both the medical and nonmedical barriers that can make nonmedical issues — bureaucratic tangles, interpersonal conflicts, institutional customs — appear to be medical issues.

• Acknowledge the powerful contribution that motivation makes to outcomes, and make changes that improve incentive alignment.

The ACOEM committee suggests that doctors be paid for disability prevention work to increase their commitment to it.

"Stop asking the treating physician to certify disability or set a return-to-work date," Christian suggests. "Instead, ask them about functional ability, unless there is a clear reason why it would be medically inappropriate for the worker to do work of any kind."

• Invest in system and infrastructure improvements.

The SAW/RTW committee advocates training practicing clinicians on why and how to prevent disability, as well as why and when to disqualify patients from work. This education should encourage physicians and other health care professionals to broaden the focus of their care to include disability prevention and to develop clinical skills in this arena.

• Disability is rarely medically required.

The ACOEM panel states that at least one formal survey and numerous informal polls of treating physicians consistently estimate that only a small fraction of medically excused days off work are medically *required* — meaning that all work of any kind is medically contraindicated. The rest of the days off work are caused by a variety of non-medical factors such as administrative delays of treatment and specialty referral, lack of transitional work, ineffective communications, lax management, logistical problems, and so on.

The fact that these days off may be unnecessary seems to be lost on the participants in the disability benefits system, Christian points out. Most workers are told only that the days off are excused and their doctor's signature sets in motion a system through which they get benefits for a diagnosed disability.

"People often end up sitting at home collecting benefits because their employers have made the discretionary business decision not to take advantage of their available work capacity," she says.

"Common-sense evidence abounds that keeping people at work and productively contributing to society is good for them and for society. To avoid the unfortunate outcome of iatrogenic or system-induced disability is worthwhile. To improve the appropriateness and usefulness of services available to people who are coping with illness and injury in their lives is also of value. And it is sensible, if not urgent, for us as a society to curtail the needless use of resources and loss of personal and industrial productivity."

The ACOEM committee report on needless disability is available at www.webility.md. ■

Study: Fewer heart deaths when QI efforts are made

Patients less likely to need readmission

Heart failure patients are less likely to die after they go home from the hospital if the hospital has participated in an organized quality improvement program, compared with patients treated at hospitals where such efforts aren't undertaken, a new study from the University of Michigan Health System finds. They're also less likely to need another hospital stay.

Those are among the key findings from a two-year study involving more than 2,500 heart failure patients treated at 14 community hospitals in and around Flint, MI.

The findings were presented at the recent

Scientific Sessions meeting of the American Heart Association.

Significantly lower death rates in the month after hospitalization were seen among patients treated at eight hospitals that cooperated to find ways to deliver proven care and educate patients about their treatment, compared with six hospitals that didn't take part in the cooperative effort.

Rehospitalization rates dropped by 22% when doctors and nurses used a "toolkit" of heart failure specific standard admission orders, inpatient clinical pathways, and discharge checklists to make sure that their patients didn't miss out on treatments or counseling.

The study was sponsored by the American College of Cardiology as part of its Guidelines Applied in Practice, or GAP project, which seeks to ensure that all hospitalized heart patients receive proven treatments, counseling for lifestyle changes, and education that can help them care for themselves after they go home.

In all, 30-day rehospitalization rates for patients treated at the participating hospitals fell from 26.1% at the start of the project to 21.7% by the end, compared with a slight increase among patients treated at the nonparticipating hospitals. The 30-day mortality rates fell from 9.4% at the beginning to 7% at the end at participating hospitals, compared with a jump from 8.5% to 10.7% in nonparticipating hospitals.

One of the keys to the success of participating hospitals was their intimate involvement in the design of the QI toolkit, says **Todd Koelling**, MD, University of Michigan (Ann Arbor) Cardiovascular Center heart failure expert.

"The keys to success were, one, that this study learned a lot of lessons from the initial GAP study," he notes. "They found they got the best responses from participation if the hospitals were able to design the instruments themselves. If I had designed it myself, the reactions from the hospitals would have been less than enthusiastic. Instead, we held meetings where the project leaders and physician champions broke into groups and designed it themselves."

Even after they came out with a common template, he notes, each hospital was allowed to change the documents to meet its own specific needs. "They felt it was theirs," Koelling comments.

In general, the tools were based on ACC/AHA guidelines, which recommend treatments based on medical evidence from research studies. Some of the tools and tactics were patterned after those already in use for heart failure treatment at the University of Michigan Health System. **(For more details, see the related story, p. 34.)**

The other key, says Koelling, was the strength of the Greater Flint Health Coalition. "They really helped organize the entire study and kept it on track," he says.

Physician participation also was critical. "The key here was that we not only involved cardiologists, but early on we tried to include as many different types of providers as possible — hospitalists, family practitioners and ER physicians, as well as nursing leadership," Koelling explains. "By doing that, no group was put in position of perhaps being defensive about their own particular type of patient population if a different physician group tried to change their treatment behaviors."

When the tools were developed, their impact was not immediately measured, he notes. "We used this iterative 'plan, do, check, act' method," he notes. "We put the tools in place, and tried to measure the effect. But not all hospitals were using them." Then, each hospital began sharing information in group meetings — what they did, how they handled reluctant physician groups, and so forth.

"By doing that with these successive meetings, the adoption of these tools really increased significantly," says Koelling. "That's why we used a 15-month period (beginning in 2003) between baseline and remeasurement; we used the extra meetings to get the use of those tools increased."

The participation of quality managers in these efforts was invaluable, he adds. "Almost all of the project leaders were quality managers of some sort. Also, one of the collaborators in the study was the Michigan peer review organization, and each project leader was in many cases the same person who would be entering data into the Q-net for their hospitals. So they were quite familiar with measuring quality."

Koelling and his colleagues soon will make the toolkit elements available on the web at www.acc.org. Meanwhile, the heart attack toolkit and framework for implementing it are now available on-line at content.onlinejacc.org/content/vol46/10_Suppl_B/.

Even though the study has been completed, says Koelling, the participating hospitals are still using the tools. "These hospitals wanted to participate," he observes. "They wanted to improve. When you look at them at the baseline, they were really quite average, but at the end they were nowhere near average. They would almost be benchmark hospitals." ■

Self-audit hospice program to identify risk areas

Expert offers guide to effective compliance

It's been more than six years since the Office of Inspector General (OIG) published its compliance program guidance for hospices, listing 28 areas in which hospices are particularly vulnerable to fraud and abuse.

Still, many hospice directors and staff are unfamiliar with these areas and could use some assistance in developing effective corporate compliance programs, an expert notes.

"In my experience, hospices that have an effective compliance program tend to be stronger hospices," says **Heather P. Wilson**, PhD, president of Weatherbee Resources Inc., a Yarmouth Port, MA-based company that provides compliance consulting and other services. Wilson is the co-chair of the regulatory subcommittee at the National Hospice and Palliative Care Organization (NHPCO) of Alexandria, VA, and the leader of the education workgroup at NHPCO.

"When we get a call from a hospice program that's in trouble, we ask if they have a compliance program; and if they don't, we help them set up one because it protects them in so many ways," she explains. "If the government sees they have a viable corporate compliance program, it can help mitigate some of the penalties that might otherwise accrue for what has happened."

Wilson was the primary author of the corporate compliance program toolkit published by NHPCO in 2000. The toolkit includes information about conducting audits and monitoring a hospice program to make certain it's in compliance with the regulations, she says.

While many of the risk areas are similar to those for home health agencies, others are hospice-specific, Wilson says.

"Some of the risk areas are related to marketing, and others are related to billing, and a number of them are related to the provision of hospice care in nursing homes," she points out. "The remainders are specifically focused on the Medicare Conditions of Participation [COPs]."

Wilson provides this short guide to what hospices can do to reduce compliance risk:

1. Set the scope of an auditing/monitoring program.

Hospices should determine which areas will be monitored on an ongoing basis and determine the frequency of audits and who will conduct the audit, Wilson says.

"Who has the best level of competency in terms of what needs to be looked at?" Wilson says. "Most hospices will have to do it internally, so who are going to be the best people to do it?"

The audit protocol might focus on these areas:

- trouble areas for the hospice;
- OIG's corporate risk areas;
- substandard care areas;
- compliance with Medicare COP;
- patient admission.

"The most significant risk area is the one of admitting patients to hospice who are not terminally ill," Wilson says.

Another risk area is when hospices bill for a higher level of care than is necessary, Wilson says.

"If you don't have documentation in your records, you could be at risk for billing for a higher level of care than is necessary," she says.

2. Include standard compliance components.

"In setting up an auditing and monitoring protocol for a corporate compliance program, audit for risk areas, but also audit for effectiveness of the compliance program," Wilson suggests.

The standard components of a compliance program are the standards of conduct, she says.

"What standards of conduct emphasize is an organization's commitment to conduct business in an ethical manner," Wilson says. "We recommend they adopt NHPCO's code of ethics because these are essentially the same thing."

It's not enough for a hospice to say that it has accepted NHPCO's code of conduct, however, she says.

"The code of conduct should be visible and posted in a prominent location with staff training material," Wilson says.

3. Customize a compliance manual.

Also, it's not helpful to purchase a compliance manual or toolkit and then let it gather dust on a bookshelf, Wilson says.

"I've actually seen it in my consulting work where a program purchased our manual and just photocopies the policies and procedures and doesn't customize them to their own organization," she says. "So that doesn't work — the manuals are intended to be helpful, but not the actual program."

A staff person should be designated to work on the tool kit or compliance manual and, ideally, a compliance officer and compliance committee should be established, Wilson says.

While it's OK to use NHPCO's code of ethics,

which is strong and touch on all aspects of hospice ethics, it's equally important to read them and internalize them, making them an organization's own code, she explains.

4. Develop policies and procedures.

"In the toolkit, we provide sample policies and procedures that are needed," Wilson says.

"You need to look at policies and procedures for each of the components of a corporate compliance program and for each of the risk areas," she says. "Also, address each risk area in terms of how you deal with those risk areas."

The risk areas are the 28 listed by the OIG. The toolkit provides samples of policies and procedures and suggestions about different components to be included, Wilson notes.

5. Find the ideal person to be a compliance officer.

"Basically, it happens in hospice all the time that you go into work one morning and your job description has changed," Wilson says. "All of a sudden, you're the HIPAA officer or the compliance officer."

While big hospice chains can afford to have a specific position designated to the role of compliance officer, smaller hospice programs have to find an employee who can fill that role while performing other tasks as well, Wilson says.

"The point of it is to have a focal point of accountability for the compliance program, and it should be someone who has the authority in the organization and who is well regarded," she says.

The person could be a clinical manager, clinical director, nurse manager, of have some other position, she adds.

"It really is a matter of looking at your organization and deciding who is the most appropriate person to take on that responsibility," Wilson says.

6. Educate staff effectively.

"You can't have an effective compliance program if the staff don't know it exists," Wilson says. "The training should be an initial training when the compliance program is rolled out and an annual inservice, as well as being included in new staff orientation."

Part of the training, which might take 45 minutes to an hour, should include an introduction to the compliance officer and information that is included in the employee handbook about compliance, she adds.

7. Establish a reporting mechanism.

The staff should know that there is a reporting mechanism in which they can report compliance concerns, Wilson says. "This can help deal with whistle-blower issues," she notes.

For example, if a hospice has a disgruntled employee who brings a lawsuit against the hospice program, then some of the damage could be mitigated by the hospice having a reporting mechanism, Wilson says.

The mechanism should give staff a way to call about potential fraud or abuse without fearing retaliation, and they should be adequately trained on how to use it, she says.

It could be a toll-free number for fraud and abuse that is established by an outside contractor, she says.

"It doesn't have to be a hotline number," Wilson says. "You could do a suggestion box or provide the contact information of the compliance officer as well."

8. Establish consequences and corrective actions.

When problems or noncompliance issues are discovered, there should be a protocol for disciplinary action, Wilson says.

"What you need is a policy and procedure that says a hospice employee would be disciplined for noncompliance with regulations or violating the organization's standards of conduct, code of

COMING IN FUTURE MONTHS

- Integrated CM services pay off
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- Legal issues that could affect your job

CE questions

9. If left untreated, postpartum depression will last no longer than six months.
A. True
B. False

10. Case managers at Keystone Mercy Health Plan make follow-up phone calls to what percentage of members who are sent a Healthy Hoops brochure and enrollment form?
A. 0%
B. 25%
C. 50%
D. 100%

11. The perception that a diagnosis alone (without demonstrable functional impairment) justifies work absence is an example of which type of medical absence?
A. Medically necessary
B. Medically discretionary
C. Medically unnecessary
D. Medically justified

12. When doctors and nurses at the University of Michigan Health System used a "toolkit" of heart failure specific standard admission orders, inpatient clinical pathways, and discharge checklists, rehospitalization rates dropped by what percentage?
A. 22%
B. 37%
C. 53%
D. 61%

Answers: 9. B; 10. D; 11. C; 12. 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. ■

ethics," she explains. "Let people know these violations are serious and there are consequences for not adhering to the compliance program."

When an audit finds problems within the hospice, it's important to demonstrate that the management will do everything necessary to correct it, Wilson reports.

"If a hospice receives an overpayment, it should immediately pay it back," she says. Also, if a compliance problem is discovered the hospice should consider retaining an attorney to assist in any governmental communication, Wilson suggests.

"What I find is that hospices are so scrupulous and so intense on doing the right things that they overdo it," she says. "They just need to be protective of themselves and their organization, so when they find something wrong their legal counsel can help them with disclosing it." ■

CE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a certificate of completion. ■