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THE OFFICIAL VOICE OF THE CASE MANAGEMENT SOCIETY OF AMERICA

CASE MANAGEMENT ETHICS

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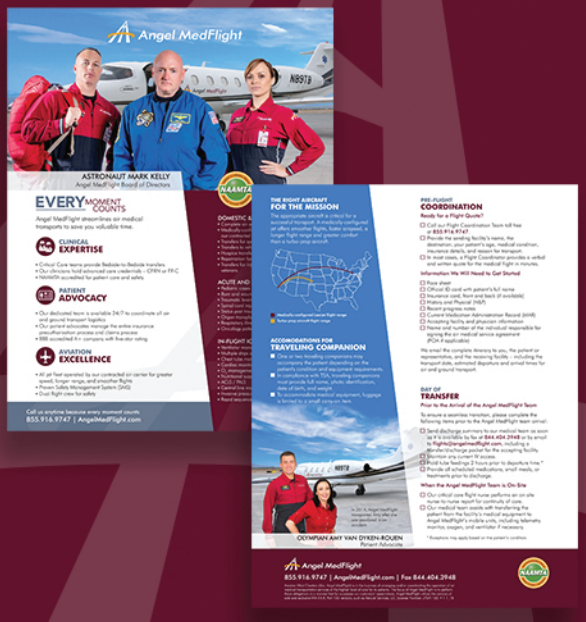

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CASE MANAGEMENT ETHICS

Case managers have a unique opportunity to marry advocacy and ethics so that each patient, client or resident served is given the opportunity to thrive through appropriate allocation of resources and education.

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Case Management Ethics: When Roles, Responsibilities and Expectations Are Not Set

BY JOSE ALEJANDRO, PhD, RN-BC, MBA, CCM, FACHE, FAAN

Oftentimes, we as case managers find ourselves in difficult situations due to our complex roles and responsibilities, the diverse populations being served, limited resources if not also conflicting viewpoints that we encounter when advocating for our patient population. As these situations occur, case managers can be thrust into ethical dilemmas without realizing that this crossroad has occurred. Unsound decision-making could impact our practice, licensure and/or certification if boundaries are crossed, even if it was unintentional or accidental.

From a systems perspective, it is important for an organization to investigate where the process broke down versus pointing blame at the individual as to the reason adverse events occurred. Case managers, regardless of practice area, are given so much to do without having a true understanding of what their roles, responsibilities and expectations are. Senior case management leaders need to provide continuous education within the department and across the organization, so that all stakeholders have a clear understanding of ethical boundaries. Research does demonstrate that when employees are overwhelmed, they sometimes will take short-cuts that can result in unexpected outcomes.

The Case Management Society of America (CMSA) provides the *Standards of Practice for Case Management* (2016 revision) as a guide that can be referenced during ethical dilemmas. More importantly, the *Standards* should be referenced as a learning tool and a reminder throughout our careers. Education on our *Standards of Practice* and general ethics should be provided during new hire orientation and during annual competencies.

The assumption that everyone knows what to do during an ethical dilemma could result in a potential violation. Ethical codes, procedures and policies have been established by professional organizations and healthcare organizations as a way to guide professional practice and behavior. Ultimately, these standards aim to help professionals do the right thing for the patient populations they serve. All case managers are first beholden to the regulations that underlie their professional licensure, as well as state-regulated certifications. Then come dependent credentials, including specialty case management certification, for they are traditionally dependent on professional licensure. Professional association standards of practice and codes of ethics follow suit.

Our complex healthcare system can cause

continued on page 8

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case managers to feel pressure to cut corners in order to save time, meet productivity metrics, financial metrics, family expectations, etc. Unfortunately, this puts patients at risk, which could result in less than ideal quality of life decisions or impact the patient or caretaker's ability to make informed decisions. Many times, that queasy feeling we may have is a warning sign that we may be heading down the wrong path. At this point, we need to stop and take time to make sure that we are "doing the right thing." It is important to also consider whether at this point we need to escalate our concerns to the appropriate organizational leader or potentially to an organization's ethics committee.

As a front-line case manager, I can recall several instances when case management leaders have set unattainable departmental outcomes, which resulted in case managers' being challenged in making the right ethical decision. Unrealistic expectations can result in our inability to appropriately care for individuals and their families. In my senior case management leadership experience, I have observed even the most ethical case managers being challenged because of the business needs of the organization. Senior case management leaders also have an ethical responsibility to advocate for all of their employees, so that healthcare system executives understand that case management professionals are required to follow the Code of Ethics and do what is right for the patients they are representing.

As advocates, case managers need to continue to champion for more internal and external resources to meet the needs of the individuals being served. We need to be knowledgeable and culturally sensitive to the needs of at-risk populations. Our goal should be to make sure individuals have the opportunity to make informed decisions about their future health or the healthcare needs of the individual they are entrusted to care for. Care management systems need to be continuously evaluated to ensure that processes are efficient and not overly complex. As we know, complexity typically results in delays and the creation of workarounds.

Licensure and certification boards also have ethics committees and other resources to prevent and address potential violations of their Code of Ethics. Case managers have a unique opportunity to marry advocacy and ethics so that each patient, client or resident served is given the opportunity to thrive through appropriate allocation of resources and education. Professional association and certification entities traditionally provide ethical advisory opinions as requested by those who are members, and/or credentialed. As professional case managers, it is important that we collaborate with our interprofessional colleagues in providing safe and exceptional care, and ultimately make the right decisions for the individuals we serve. ■

Jose Alejandro, PhD, RN-BC, MBA, CCM, FACHE, FAAN
President, CMSA 2018-2020
Dr. Alejandro *is the Director of Case Management at UC Irvine Health, Orange County's only Level 4 Trauma and Burn Center.*

WHAT HAPPENS IN VEGAS? CMSA ANNUAL!

Are you ready for another great CMSA event? Save the date and register today for our 29th Annual & Conference & Expo in Las Vegas, NV, on June 10-14, 2019! Early bird pricing is now available. Visit **wearecasemanagement.com** for details!

CMSA HONORS CASE MANAGER OF THE YEAR, NEW BOARD MEMBERS INSTALLED AT THE 28TH ANNUAL CONFERENCE & EXPO

The Case Management Society of America is proud to announce the recipient of the Case Manager of the Year and the installment of new national board members at the 28th Annual Conference & Expo in Chicago in June 2018.

The 2018 Case Manager of the Year was awarded to Carol Garner, RN. She has been described as a pioneer, a leader, a mentor, an inspiration, a relationship builder, an innovator, and is known for expanding her passion for case management globally.

Carol began her nursing career in 1975. In 1998, Carol took a leap and challenged the "Pre-auth Only" environment by appointing one of the first case managers for South Africa. Despite a huge resistance from an industry that saw case management as negative and very strange, a case management team was successfully put together and changed healthcare. Carol has been touted as responsible for changing the way an entire country is understanding and experiencing case management; she was even able to win over the initially skeptical and sometimes hostile treating specialists through relentless preaching of her vision.

After attending the 2010 CMSA Annual conference, Carol was key in launching the Case Manager Association of South Africa to represent the case managers of South Africa. She not only carries the title of founding member, but continues to chair the association. In less than a decade, CMASA has grown to over 1,000 members. She continues to expand her relationships with other case management organizations. Beyond her connections with CMSA and CMSUK, she has recently been approached to mentor the development of sister associations in Dubai, Nigeria and Botswana.

Carol was also inspirational in supporting and contributing content to the first official certified case management course for South African case managers; she has since ventured out on her own to launch her own case management company, Global Case Management.

Carol has stated, "I am both honored and humbled to be the 2018 recipient of the CMOY award and to think that this is the first time it's been awarded internationally makes it even more special. Case management in South Africa has only developed as much as it has through the support and commitment of the U.S. for which we are eternally grateful, we learn more and more with every interaction.

"Allowing us to use your Standards of Practice to set the benchmark for the gold standard in SA is so appreciated because we had nothing to go on, no guidelines and no minimum criteria. Using these standards in the case management setting has definitely improved the quality and approach to case management.

"In my personal capacity, I am already seeing a different level of respect and awareness, and there has been an increase in the number of client referrals to my company, which is awesome. There is no doubt the association will be taken more seriously now, and we will be able to step it up a gear.

"To reiterate what I said when accepting the award and quoting John Sailsbury from the 12th century:

"'We are like dwarfs sitting on the shoulders of giants. We see more, and things that are more distant, than they did, not because our sight is superior or because we are taller than they, but because they raise us up, and by their great stature add to ours.'

"CMSA has been our giant, and we thank them for allowing us to sit on their shoulders."

Also taking place was the installment of new national board members. Among them include:

PRESIDENT

Jose Alejandro, PhD, RN-BC, CCM, FACHE, FAAN, 2018-2020

IMMEDIATE PAST PRESIDENT

Mary McLaughlin-Davis, DNP, ACNS-BC, NEA-BC, CCM, 2018-2019

DIRECTORS

Catherine Campbell, MSN, MBA, CHC, FACHE, CCM
2018-2021
Andrea Norton, BSN, CCM
2018-2021

ADVISORS

Angie Millan, DNP, RN, FAAN
2018-2020

New CMSA President Dr. Jose Alejandro noted, "I am excited at the opportunity to lead a dynamic and energized group of industry leaders who are committed to the furtherance of professional case management. We need to continue to be advocates for the patients we serve."

CMSA sends congratulations to our winners and thanks everyone who helped with the process. For information about CMSA's Awards, visit **http://www.cmsa.org/Awards**.

CMSA STANDARDS OF PROFESSIONAL CASE MANAGEMENT PRACTICE PROGRAM

CMSA's *Standards of Practice for Case Management*, serves as a unifying force for professional case management practice by providing a common understanding and application of the role, process, and expectations. The Standards serve to drive best practice accountability for individual professional case managers as well as for organizations.

This new online course is designed to enhance understanding by expanding on these common principles to deliver a more unified education to professional case managers creating quality skill sets across the healthcare continuum. The coursework embraces the case management care continuum in any work environment, which contributes to consistency in foundational case management knowledge and a long, sustainable workforce.

The course is made up of 16 online modules each representing the sections of the CMSA Standards of Practice, including one on each of the 15 Standards. Each module contains a detailed narrative with enhanced explanations of that Standard including bibliographies, references, and a professional video presentation of that narrative content with downloadable slide handouts, which incorporate case scenarios showing real-life situations in order to better understand that Standard. This course is pre-approved for 32 hours of continuing education credit for RN, SW, and CCM.

Consider participating if you are:

- A case management department looking to build a long term sustainable workforce that advocates for standardized practice in order to produce positive case management outcomes.
- A new case manager entering the field and looking to become proficient on the *Standards of Practice for Case Management*.
- A case manager looking to enhance their case management knowledge and earn continuing education to meet their licensure or certification requirements.
- A recruiter who wants to learn more about case management for a more consistent and concise process of identification, selection, orientation, and on-boarding of new case management staff.

Individual Rates

Members: $360*

Non-Members: $440

To learn more and register, visit

http://www.cmsa.org/sopcmcourse/

IN MEMORIUM

Linda Anne Brown, a former CMSA member who was instrumental in bringing the military and VA case management community into the CMSA fold, passed away on Thursday, May 31, 2018, after a long battle with both multiple sclerosis and Huntington's disease. Linda is survived by loving daughter and son-in-law, Laura and Jonathan Thompson of Arvada, CO; grandchildren, Samantha, Brandon and Brian; devoted sister and brother-in-law, Denise and Tony Iacangelo of Reston, VA, along with many cousins and friends.

Linda will be remembered for her sweet, fun-loving nature, her Christian devotion and her determination in the face of adversity. Her distinguished career with the federal government spanned more than 28 years, culminating in special recognition from the Surgeon General of the Navy for her dedicated work in case management. Linda established the Navy Medicine's case management program from the foundation up and built a collaborative network of Navy case managers to implement services that met the complex health care needs of active duty sailors, Marines and their beneficiaries.

Read more about Linda here:

https://www.legacy.com/obituaries/washingtonpost/obituary.aspx?n=linda-brown&pid=189376403

CMSA BOARD OF DIRECTORS SPOTLIGHT

Betty Overbey, RN, CRRN, CDMS, CCM, CRP, MSCC, has over 30 years' experience as a case manager handling all types of complex illness and injury cases and has built a reputation for catastrophic injury management. She is versed in working with different benefit systems including group health, workers' compensation and long-term disability. She also provides consultative services and case management to individual patients and their families. She also functions as a Life Care Planner and medical/legal consultant.

As an owner of a small business, she serves as an educator and mentor in the field of case management. She is published and has presented on various case management topics. Ms. Overbey is currently a member of the national board of directors of the Case Management Society of America.

UPDATE YOUR CONTACT INFORMATION TODAY

If you are a CMSA member and have moved, changed email addresses or started a new job, let us know! Visit **cmsa.org/clientservices** to update your information online, or contact us by phone at 501-225-2229.

CONNECT WITH THE CMSA COMMUNITY ONLINE

If you'd like to communicate with other case managers and healthcare industry professionals across the country, connect with CMSA on LinkedIn™, Facebook, Twitter, and Pinterest!

CMSA's LinkedIn™ Group alone has more than 17,000 members, where new discussions emerge daily.

We look forward to seeing you there!

Facebook: /cmsanational

Twitter: @CMSANational

LinkedIn: Search "CMSA"

Pinterest: /CMSANational ■

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As of 8.2.2018

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Highlights of the 28th Annual Conference & Expo

Outgoing Board of Directors (2017-2018)

We had another fantastic conference event this June in Chicago! The CMSA Board of Directors and staff thank the attendees, exhibitors, sponsors and speakers who made this year's conference and expo such a memorable experience.

We hope you will join us in 2019 as we take CMSA's Annual Conference & Expo to the Mirage in Las Vegas, NV! Visit **wearecasemanagement.com** to learn more and take advantage of early bird rates!

Incoming Board of Directors (2018-2019)

Chapter Award Winners

The Chapter Excellence and Innovation Award for Conference Planning
Winner: Kansas City Chapter of CMSA

The Chapter Excellence and Innovation Award for Chapter Educational Programming
Winner: Long Island Chapter of the Case Management Society of America

The Chapter Excellence and Innovation Award for Membership Development
Winner: Case Management Society of Oklahoma

The Chapter Excellence and Innovation Award for Publishing and Promotions
Winner: Greater Grand Rapids/Kalamazoo Chapter of the Case Management Society of America

The Chapter Excellence and Innovation Award for Public Policy & Advocacy
Winner: Alamo Chapter - Case Management Society of America

The Chapter Excellence and Innovation for Best Use of Technology Award
Winner: CMSA Chicago

The Chapter Excellence and Innovation in Chapter Revitalization Award
Winner: CMSA San Diego

Opening Night

Public Policy Forum ("We Are Professional Case Managers!")

Selfies at Registration

Military Day

Military Day Keynote, Bryan Anderson

Mary McLaughlin-Davis and Kathleen Fraser

1K Cash Giveaway Winner

Cash Winners

Expo Hall

Conference Sessions

Color Guard

Rebecca Perez and Kathleen Fraser

Thursday Keynote, Dr. Travis Stork

Friday Keynote Speaker, Dr. Allan Hamilton

International Members

Case Manager of the Year, Carol Garner, RN

Case Manager of the Year, Carol Garner, RN

Saturday Keynote Speaker, Rick Rigsby

Gavel Passing : Mary McLaughlin-Davis and Jose Alejandro

THE ETHICAL CASE MANAGER MAKING A DIFFERENCE

BY KATHLEEN FRASER, MSN, MHA, RN-BC, CCM, CRRN

"Courage is being scared to death and saddling up anyway."
– John Wayne

Ethics are moral principles that guide a person's behavior. All decisions have an ethical or moral dimension for a simple reason: They have an effect on others. In case management, ethical behavior exists to foster and preserve our clients' welfare. Unethical behavior, by definition, fails to do so because it is self-serving.

Case managers are routinely confronted by gray ethical areas due to having to deal with multiple stakeholders or points of view. Case management is neither linear nor a one-way exercise, with assessment responsibilities occurring at all points in the process. Facilitation, coordination and collaboration occur throughout the client's healthcare encounter.

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Regardless of a professional's title or area of expertise, the case manager is dealing with complex cases in which there may not be a clear right and wrong. If we want to preserve the ethical ethos of case management, case managers must know the ethical standards/scope of practice to which they are held and comply with them.

In professional case management, the Case Management Society of America's (CMSA) *Standards of Practice for Case Management* (rev. 2016), is the gold standard in which a majority of case management departments in the world base their policies, procedures and ethical guidelines. Developed and sustained by CMSA, the *Standards of Practice for Case Management* require that the case manager empowers the client to problem-solve by exploring options of care, when available, and alternative plans, when necessary, to achieve desired outcomes. They encourage case managers in the appropriate use of healthcare services and to strive to improve quality of care, maintaining cost effectiveness on a case-by-case basis. The *Standards* cover how to assist the client in the safe transitioning of care to the next most appropriate level and to strive to promote client self-advocacy and self-determination. Finally, the *Standards* guide case managers to advocate for the client, employer and the payer to facilitate positive outcomes for all stakeholders. However, if a conflict arises, the needs of the client must be the priority. A case manager's primary obligation is to his or her clients.

ETHICAL PRINCIPLES OF CASE MANAGEMENT

It is critical to be aware of the five basic ethical principles in case management, which include:

- **Beneficence:** Always do good.
- **Non-malfeasance:** Do not purposefully do harm.
- **Autonomy:** Treat each person as an individual. One size does not fit all!
- **Justice:** Assist clients to obtain what they deserve, in a good way.
- **Fidelity:** Do not make promises you cannot keep.

Case managers are financial stewards and are responsible and fiscally thoughtful in their management of resources. Because cost containment is essential, case management becomes essential; however, this role can result in increased responsibility and increased risk to the case manager. Case managers basing a decision concerning a patient's care on cost savings **alone**, without regard to the quality of the treatment regimen, must not occur. A perceived lack of advocacy for the client/patient, challenges in the area of timeliness and not holding a license in the state where case management is performed are also areas that can leave case managers at risk.

Timely follow-through is one of the essentials areas of the case management practice. A lack of follow-through with a physician or other appropriate healthcare provider by the case manager is problematic, as is the failure to inform the patient of the **essential need** for a follow-up appointment after discharge. This type of follow-through should be present throughout service.

However, follow-through alone is not enough! Not only does timely follow-through need to occur, accurate and complete documentation of the follow-through must as well. Timeliness alone also is not enough. If the individual is not compliant, or there is an inability to successfully contact the patient, these actions must also be documented to show whoever reads the medical record that you complied with your legal and ethical responsibilities to the patient.

The case management process is carried out within the ethical and legal realm of a case manager's scope of practice, using critical thinking and evidence-based knowledge. *"The ethics of excellence are grounded in action—what you actually do, rather than what you say you believe. Talk, as the saying goes, is cheap."* – Price Pritchett

Client-centric case management involves individualized and goal-directed care — a collaborative, partnership approach. Whenever possible, case managers should facilitate self-determination and self-care through the tenets of advocacy, shared decision making and education. In other words, turn the passenger into a driver!

It is important to use a comprehensive, holistic approach. Practice cultural competence, with awareness and respect for diversity. One example of this cultural competence would be if you have a patient/client who is entering a religious holiday or period in which he or she is not allowed to eat from sunrise to sunset. However, the patient is on many medications which must be taken with a snack or food three to four times daily. Compliance issues are likely to occur, if not untoward side effects; therefore, the case manager should alert the physician in case there may be long-acting alternative medications.

Another element can occur when communicating with non-English speaking patients. In this case, use a professional medical translator if at all possible. This way, the communication is less likely to be affected by "false fluency" with medical phrases. However, even with a translator, case managers should use words or phrases that are more easily understood by lay people. Also inform a translator you want translation as literal as possible, and for them to tell you if there is not a literal translation, to avoid confusion. Ensure in advance the translator understands the need for confidentiality and, in turn, make sure the patient understands the conversation will be confidential. Be sure to watch the patient while the translator speaks, and when the patient replies, pay attention to the body language. And lastly, speak directly to the patient as if the translator were not present, allowing your words to be translated exactly as spoken.

ENHANCED NURSE LICENSURE COMPACT (eNCL)

The Enhanced Nurse Licensure Compact (eNCL) increases access to care while maintaining public protection at the state level. The eNLC was implemented as of January 19, 2018.

When RNs, and therefore RN case

"In professional case management, the Case Management Society of America's (CMSA) *Standards of Practice for Case Management* (rev. 2016), is the gold standard in which a majority of case management departments in the world base their policies, procedures and ethical guidelines."

managers, practice (onsite or telephonically) across state lines, they are required by law to be licensed in each state in which their patients receive treatment, not the state in which the patient resides (although it is usually the same thing). The individual RN who is not licensed currently does not meet the Nursing Licensure Standards of Care and in fact is engaged in criminal behavior as seen by the law, rules and regulations, because he or she is practicing without a license in that particular state.

For a registered nurse to qualify to be considered in the compact, he or she must reside/live in a compact state. Holding a license in a compact state while not residing in a compact state does not qualify. Penalties for providing nursing services (which again includes case management) without a license range from a $1,000 fine to 1 year in jail to lifetime prohibition from practice. This situation leaves the case manager:

- In an ethical conflict
- In a legal conflict
- With his/her own professional license on the line
- With his/her personal and family assets at risk in case of an incident causing harm to a patient

The eNCL is important, as it enables nurses and nurse case managers to provide care to patients in other eNCL states, without having to obtain additional licenses.

TRUST YOUR ETHICAL INTUITION!

Case managers have the responsibility to emphasize communication and collaboration across multiple points of interface over our healthcare continuum. We can expect to maneuver gray areas and have the opportunity to review ethical dilemmas as a positive. If a case manager feels uncomfortable being asked to do something he or she thinks is unethical, it probably is! To help during times of conflict with ethical decision making, speak to a coworker, friend or supervisor. Another suggestion can be to create an ethical decision-making tree. There are many types of such trees, and one can google "decision-making tree" and choose as to how detailed or how broad.

"BE THE THERMOSTAT, NOT JUST THE THERMOMETER"

– Dr. Martin Luther King.

Don't just sit around and complain about a situation; do something about it! When it comes to ethics, as in most situations, go back to the basics. Use the critical thinking steps you've learned over your years of practice, suspend judgment and deconstruct the situation. Then reflect on the situation and synthesize to create the solutions we as case managers were born and taught to create.

CASE MANAGER SURVIVAL SKILLS:

- Recognize your worth
- Keep a sense of humor
- Keep things in perspective
- Embrace change
- Always have a plan B, C, D or E!

And remember, "*You are never wrong to do the right thing!" – Mark Twain.* ■

SOURCES

www.cmsa.org
https://www.ncsbn.org/compacts.htm-National Council of State Boards of Nursing
http://www.cmsali.org/pdf/public_policy/2014/MultiState%20Licensure.pdf

Kathleen Fraser, MSN, MHA, RN-BC, CCM, CRRN, *is a Registered Nurse, a Certified Case Manager, Certified Rehabilitation Registered Nurse and Board Certified in Case Management with the American Nurses Credentialing Center. She holds a Masters' Degree in Nursing and also a Masters' Degree in Health Care Administration.*

Kathy served a two-year term as the National President of Case Management Society of America from 2014-2016 and currently serves as the Executive Director of CMSA.

In June 2016, Kathy was presented CMSA's prestigious National Case Manager of the Year Award.

SYMPTOM MAGNIFICATION: HOW TO DISARM AND ENGAGE

BY JAIME SIGURDSSON, CEAS

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When an injured worker presents to a medical professional with symptoms that don't match his or her diagnosis or seem "exaggerated," what is the expected plan of care? How do you determine which symptoms are sincere? Which limitations are valid? What is an appropriate treatment plan? And how many diagnostic tests do we allow? As medical professionals, how do we identify injured workers who present with symptom magnification, and what is the best course of action?

In order to answer these questions, we must first define symptom magnification and explain the difference between magnification and malingering. By medical definition, symptom magnification is the conscious or sub-conscious behavioral pattern where the individual's subjective reports of symptoms are inconsistent with the known impairment. These individuals exhibit a tendency to under-rate their abilities and/or over-state their limitations; however, it does not imply intent. Malingering is the term used when the magnification is both conscious and intended for a variety of secondary gains, such a financial compensation; avoiding school, work or military duty; obtaining drugs; or getting lighter criminal sentences. Malingering is often tied to fraud, whereas symptom magnification without the goal of a secondary gain may just require

"It is essential for the medical professional to disarm the fear that leads to magnification of symptoms and arm injured workers with knowledge of the recovery process so that they can improve their potential for successful recovery. When an injured worker is committed to his/her rehabilitation, the success rate increases exponentially."

a deeper interaction between the medical professional and the patient to determine the cause of the behavior.

In order to determine symptom magnification, all injury evaluations should initially determine if subjective complaints correlate to impairment. If there is questionable correlation, then the medical professional should perform distraction-based testing for under-rated functional limitations and compare pain questionnaires to reported and tested function to determine inconsistencies. When symptom magnification is identified but not associated with malingering, then the goal should be to overcome that behavior.

Symptom magnification is most often identified with the following risk factors: low job satisfaction, monotonous/repetitive work, lower education level, adverse employee-employer relations, recent/new employment, frequent lifting and ongoing litigation or multiple claims. These risk factors are often in conjunction with the injured worker struggling to be heard. Having a hard time coping with the pain or struggling with the loss of function may lead to exaggeration of symptoms. It is essential for the medical professional to disarm the fear that leads to magnification of symptoms and arm injured workers with knowledge of the recovery process so that they can improve their potential for successful recovery. When injured workers are committed to their rehabilitation, the success rate increases exponentially.

The worst reactions a medical professional can perform when confronted with positive symptom magnification include lack of empathy or frustration with subjective complaints; rushed appointments with minimal time to listen to the patient; and not explaining the recovery time, the process of healing, and the expectations for pain, edema and gradual improvement in function. When a worker gets injured, just like any other injury, the initial reaction is fear.

However, the difference between an injured worker and someone who injures himself when not working is the ability to guide and determine his medical treatment. An injury that does not occur at work allows the injured to make all treatment decisions, whereas the injured worker is told which doctor to see, when treatment is authorized and which medications they are approved to take. When people have to give up control, many times they feel unheard. Although the medical professionals chosen for the injured workers are often the best in their field, the choice of provider was not made by the injured worker, and therefore preconceived notions of "not being in their best interest" are often formulated. If this is in fact the belief of the injured worker, then the goal is to disarm and engage from day one. However, often this is not the case and therefore their need to be heard is compounded with each and every medical choice that is made for them.

Physical therapy is often the easiest place to disarm and engage due to the frequency and duration of the rehabilitation process. As opposed to having a monthly appointment with the physician, the injured worker may attend therapy two to three times a week for up to 8 weeks depending on the extent of the injury. If the therapist can disarm any fear or need to exaggerate symptoms during the initial evaluation while including the patient in his or her treatment plan and goals, the road to recovery can be fast and the ability to return to work is improved. This commitment to the injured worker's recovery by the therapist allows the patient to commit to his or her care each and every visit and trust the rehab process. Without the commitment from the patient and the understanding of realistic expectations, there is a risk of delayed or prolonged recovery.

In addition to physical therapy, all medical providers can help overcome symptom magnification by acknowledging the subjective complaints but putting more weight on the objective findings and test results. It is vital for the medical providers to listen to the injured worker's concerns and then have a discussion about the expected symptoms that correlate with the diagnosis and the normal course of treatment. It is important for the medical provider to be the authority and expert and direct the plan of care. When patients are given the expected rate of recovery and have reasonable expectation of residual pain while feeling heard, they are more likely to accept the process and return to work when able to perform the essential job demands safely even if not yet at prior level of function or without pain.

When symptom magnification is unable to be overcome, the medical providers must maintain the appropriate plan of care, limit discussions of exploratory surgery, avoid multiple diagnostic tests and limit continued treatment. Continued evidence of symptom magnification with no evidence of objective findings should result in rapid assignment of MMI and release to work.

With a goal of return to work, all barriers to rehabilitation should be identified, including symptom magnification. And when the barrier has the potential to be overcome, then it's the responsibility of the medical provider to acknowledge the limitation to recovery and make every attempt to eliminate or reduce its role in the patient's treatment. By listening to injured workers, disarming and engaging them and allowing them to commit to their recovery, one can facilitate faster discharge to work and back to function. ■

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ACHIEVING PATIENT WELL-BEING THROUGH MENTAL HEALTH INTEGRATION & TEAM-BASED CARE

A Look at Intermountain Healthcare's TBC Model

BY BRENDA REISS-BRENNAN, PhD, APRN

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One in five adults in the U.S., and nearly 43 million people, experience mental illness during a given year. In addition, the cost associated with lost productivity in America for mental illness is $193 billion annually, according to the National Alliance on Mental Illness.

As mental health evolves into a growing global priority, healthcare organizations across the world are becoming increasingly more burdened in their ability to effectively manage the associated costs in terms of quality of life and overall financial sustainability.

The place where the burden is most felt is at the doctor's office. A majority of Americans suffering from mental illness and substance abuse disorders usually seek treatment at primary care facilities.

INTERMOUNTAIN AIMS TO SOLVE THE MENTAL HEALTH CRISIS THROUGH MENTAL HEALTH INTEGRATION (MHI) AND TEAM-BASED CARE (TBC)

Integrating mental and physical healthcare is imperative to delivering whole-person care and helping patients live the healthiest lives possible. Properly diagnosing and treating mental health disorders in primary care through an effective integrated care team is vital to the delivery of high-quality care and achieving population health. If not managed at the primary care level, the burden and need become burdensome for patients and their families, as well as other care locations not able to meet patients with mental healthcare needs.

Intermountain Healthcare has aimed to deliver the highest quality of care at the lowest possible cost to patients through the delivery of Mental Health Integration (MHI) and Team-Based Care (TBC). The TBC model provides a standardized clinical and operational care process that engages patients and families in primary care and incorporates mental health resources and supports into the primary care setting. In 2000, Intermountain embedded mental health screening, assessment and treatment tools within its primary care physician offices, investing in mental health integration. Today, it continues to utilize this approach as a foundation for assisting patients and care teams in more effectively treating and managing the full spectrum of chronic conditions: mental and physical.

"Integrating mental and physical healthcare is imperative to delivering whole-person care and helping patients live the healthiest lives possible. Properly diagnosing and treating mental health disorders in primary care through an effective integrated care team is vital to the delivery of high-quality care and achieving population health."

HOW TBC DIFFERS FROM TRADITIONAL CARE PRACTICE

In many primary care practices across the country, traditionally, patients are referred elsewhere for mental health treatment. Within primary care clinics that have MHI, mental health conditions are treated in the same primary care practice. Patients are screened for potential mental health conditions, social determinants and suicide risk, and a personalized care team is assembled according to the patient's determined overall complexity. The care team and medical home context provide a safe environment in which conversations can be initiated and education provided relative to the care and management of their mental health needs.

In the MHI model, the approach is to normalize mental health through integrated team-based care. The patient is treated with respect, comfort, and confidence regardless of the condition. The model encourages early detection, prevention and education, as well as intervention with the appropriate level of care team support to help patients with their mental health conditions. A transparent data system is shared with all team members for ease of communication and care coordination. All providers — nurses and physicians alike — are trained to assess the patient for early recognition of mental illness through patient screening and assessment tools.

TEAM-BASED CARE SHOWS ITS WORTH

It has been proved that patients are happier when they are treated as a whole person.

In 2016, a 10-year Intermountain Healthcare study in *JAMA* called "Association of Integrated Team-Based Care with Health Care Quality, Utilization, and Cost" identified the effectiveness of integrating mental and physical health. This landmark study demonstrated that integrating mental health in primary care by utilizing the Team-Based Care model produced dramatically better patient outcomes, more appropriate utilization of healthcare services and lower costs.

The study results showed:

- A higher rate of patients screened for depression – A 22 percent increase.
- A lower rate of emergency room visits – A reduction of 23 percent.
- A lower rate of hospital admissions – A reduction of 10.6 percent.
- Better patient care through improved care management – Primary care physician encounters reduced by 7.0 percent.
- Lower payments to providers – $3,400 for patients in team-based practices versus $3,515 for patients in traditional practices for a savings of 3.3 percent.

For patients, the bottom line is that getting care in a Team-Based Care setting where medical providers work hand in hand with mental health providers results in higher screening rates, more proactive treatment and better clinical outcomes for complex chronic disease.

SHARING TEAM-BASED CARE MORE BROADLY

The TBC model has spread to other healthcare organizations throughout the country, implementing team-based care approaches to healthcare delivery. Over the last eight years, Intermountain Healthcare has collaborated with more than 45 outside organizations across both the contiguous United States and among the global communities of Sweden, France, the United Kingdom, New Zealand and Australia in support of the implementation of MHI through a team-based care model. Collaboration includes standardized training, routine team consultations and yearly continuing medical education and training conferences, where diverse team stakeholders share lessons learned and design innovative solutions to improve upon the model.

Recently, Intermountain launched an integrated behavioral health company called Alluceo, to continue sharing innovations associated with mental health integration and team-based care. Alluceo is in the process of taking team-based care processes and making them digital and virtual for care teams and their patients. The anticipation for Alluceo is that making team-based care processes more digital will make the TBC experience more effective in reaching patients and their needs. Digitizing best practice will enhance and streamline care delivery, and ultimately provide mental healthcare services much faster and more efficiently for clinic care teams to give for their patients.

DISCOVERING THE VALUE OF TEAM-BASED CARE

TBC has shown to be successful in delivering MHI, and shows potential to be scaled and extended toward many disease states, conditions and patient demographics. Within Intermountain, this team structure has provided the foundation for performing Personalized Primary Care (PPC) and has standardized the TBC strategy for executing population health management. While this approach requires sustained support from leadership, investment in leadership, clinical and analytic workforce, robust information systems and quality incentives, the savings toward healthcare providers exceeds the cost and is sustainable.

In a value-based world, TBC and MHI will be critical components of doing population health. The elements of Team-Based Care will allow for organizations to realize the benefits of population health, increasing savings and providing whole-person, high-quality care for patients more broadly. ■

Brenda Reiss-Brennan, PhD, APRN, *is the Mental Health Integration Director for Intermountain Healthcare.*

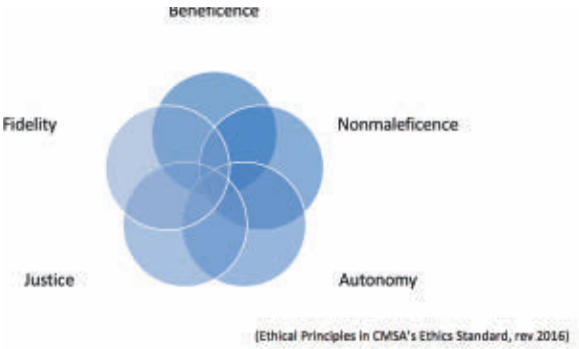
IS UNPROFESSIONAL BEHAVIOR UNETHICAL?

BY TERESA M. TREIGER, RN-BC, MA, FABQUARP, CCM

Our *Standards of Practice for Case Management* presents Ethics as Standard K. The standard leads with, "The professional case manager should behave and practice ethically and adhere to the tenets of the code of ethics that underlie her/his professional credentials (e.g., nursing, social work, and rehabilitation counseling)" (CMSA, 2016). This statement not only sets the tone and expectation of ethical practice but it clearly highlights the importance of behavior.

Consider your interactions with case management colleagues across the continuum of care. Maybe you have been part of, or witnessed, one of these scenarios:

- Lack of cooperation in setting up or executing a transition of care plan



(Ethical Principles in CMSA's Ethics Standard, rev 2016)

- Allowing an incoming call to go to voicemail instead of picking up
- Paperwork for a skilled nursing facility transfer where handwriting is illegible
- Someone being less than receptive to questions from another case manager

Do these examples exemplify patient care excellence? Let's draw a line in the sand and agree that they do not. Unfortunately, these are actual examples of unprofessional behavior observed over the lifetime of my career. The question we are faced with is, does unprofessional behavior equate to unethical behavior?

Rather than expound on the details of ethical principles and models, let's consider them within the context of a scenario. The baseline facts are contained in colored boxes: green for the hospital and blue for managed care. This is followed by a large gray box that provides a detailed scenario.

Southwest General (SGH) has a 450-bed capacity. For the past month, SGH maintained an average daily census of 35 Major Health Care (MHC) members. Elective procedure authorizations are submitted at the rate of 10-15 per day. Emergency admissions average three to five per week. Historically, SGH provides a daily census of Major Health Care's (MHC) inpatient population. Admission and concurrent reviews of inpatient MHC members are communicated via the new web-linked information exchange. SGH has been an enthusiastic supporter of the new system.

In 2017, Major Health Care, a regional managed care plan, rolled out a new information exchange system which vastly improved efficiency and turnaround timeliness for utilization review decisions. In before-and-after testing, decision timeliness improved for both authorization and concurrent stay reviews by 80 and 75 percent respectively. While there was widespread enthusiasm and acceptance by contracted providers and suppliers, there are a few individual holdouts within organizations. The MHC policy has been to roll out the system in all acute care settings first and to allow a period of time for facilities to acclimate to the new process. A taped training session was provided in a 24/7 accessible webinar. When necessary, a site visit was scheduled. The pressure was on to get all in-network hospitals using the new system because of the validated improvement as well as the desire to begin working with other providers and vendors to transition to the new system.

Margaret Overhing is a managed care case manager at MHC. She has been an employee of the plan for 5 years. Her assignment focuses on adult admission authorizations and concurrent review and transition planning at SGH. She is known as a diligent worker. She usually eats lunch in the cafeteria with co-workers. Margaret works closely with SGH to transition all case managers to the new system. She also offered 1:1 sessions to all care continuity department staff. There is one holdout who has been completely resistant to adopting the new system. Margaret advised her supervisor about the situation. She also mentioned that not only is the person resistant to change but that she has become increasingly verbally abusive. The supervisor advises Margaret to document all interactions with the person. She also places Margaret's phone line on record status in order to assess the situation.

After 25 years at SGH, Narcissa "Narcy" Dermo is ready to retire in 6 months. She originally worked as a bedside nurse before moving to the care continuity department 10 years ago following a job-related back injury. Despite Margaret's offer to walk her through the new MHC review entry process, Narcy continues to send all of her review information via fax. She makes repeated phone calls demanding expedited reviews when her updates are not adjudicated as swiftly as those of her colleagues (all of whom are using the new system). When additional information is required to complete a review, Narcy again faxes it. Any time Margaret calls Narcy directly, she lets the call go to voicemail. Occasionally, Narcy does not include all requested information in her follow-up fax. This which triggers another round faxing. Narcy's interactions with Margaret have become increasingly contentious. She berates Margaret for being inept at her job and slow.

It is the Wednesday prior to a holiday weekend. For the past two days, Margaret facilitated transition plans for six SGH patients. She is actively involved in planning. On the whole, the SGH case managers are adept at transition planning and contact Margaret via phone when plans involve more service or equipment authorizations in order to facilitate the authorization process.

Narcy has four patients ready to transition by Friday. Margaret has not received any of Narcy's transition plans, so she has cleared as much of her work as possible to accommodate the imminent flurry of activity. Narcy's transition plans frequently take longer to turn around. This is mostly due to missing information and her refusal to use the new system. Margaret's supervisor checks in regularly in anticipation of last-minute reviews and requests.

It is now Thursday morning and none of Narcy's transition plans or updates have been received. By 2:45 p.m., the first of Narcy's patient reviews arrives via fax. There is missing concurrent review from the previous two days. Before Margaret has the chance to call, the second review arrives. This is missing a concurrent review and vendor details for oxygen and other supplies. At 3:30 p.m., Margaret places a call to Narcy to request the necessary information. Her call goes to voicemail. Margaret documents the time and content of the requests for additional information.

At 4:15 p.m., the third and fourth patient reviews arrive via fax. The pages of each review are out of order; it is difficult to know which page refers to which patient. Margaret leaves a second message on Narcy's voicemail to alert her to the problem. Margaret specifically asks for a call back to help her sort the pages. She notifies her supervisor of the situation.

By 4:45 p.m., neither the additional information nor a return call has been received. Margaret waits for an additional 15 minutes beyond her usual hours just in case something arrives. Margaret's supervisor places a call to the CM Director at SGH. She emphasizes that Margaret left at 5:15 p.m. and that even if information arrives, determinations will resume in the morning.

It is Friday morning and Margaret checks her voicemail to find a tersely worded, insulting voicemail from Narcy. She calls her supervisor over to listen. It is decided that another MHC case manager who is familiar with SGH will process the remaining transition plans. The voicemail message is saved. By the end of the day, three out of the four transition plans are approved. The fourth plan was withdrawn. Margaret's supervisor schedules a site visit with the SGH Director of Care Continuity for the following week.

Take a moment and consider three questions:

- What is your initial reaction to this chain of events?
- Has Narcy or Margaret behaved unprofessionally?
- Does the unprofessional behavior equate to unethical behavior?

This type of situation is not uncommon. Client engagements across the care continuum have revealed similar dysfunctional situations, often between case managers working in different settings (e.g., provider versus payor). Workplace violence has been defined as violent acts directed toward workers, includes physical assault, the threat of assault and verbal abuse and is widely recognized as having far-reaching consequences for workers' health and safety. Nurses and social workers are known to be at high risk (Gacki-Smith et al., 2009).

Incivility, bullying and violence in the workplace are serious issues in nursing (American Nurses Association, n.d.). Workplace bullying is defined as "repeated, health-harming mistreatment of one or more persons (the targets) by one or more perpetrators." Bully behavior is marked by abusive conduct that is threatening, humiliating or intimidating, work interference/sabotage that prevents work from getting done, or verbal abuse (Workplace Bullying Institute, 2015).

The fallout related to bullying is often felt as an emotional toll on the individual as well as the workforce. The resulting trauma influence is multi-factorial. Who among us would continue to work in a hostile environment? Workforce retention is a major concern for employers who already struggle to find qualified professional workers. Consider the state of mind of someone who is being bullied and whether the person is functioning at top speed. The weight of working in a hostile environment certainly carries through to carrying out one's responsibilities; ergo, care quality may be affected. In addition, a hostile environment is simply not safe. Fink-Samnick pointed out that "when professionals feel disempowered to address the dynamics of bullying, whether manifesting as insults and/or threats toward them and/or patients and families, the outcomes can and will be deadly" (2014).

Was Margaret's behavior unprofessional and/or unethical? When I've posed this question at training sessions and seminars, people were in general agreement that Margaret's behavior was neither. However, when the same question was asked of Narcy's behavior, the entire class was emphatic in their belief that her conduct was unprofessional. In some cases, it took a bit of discussion, but eventually people rallied around the conclusion that Narcy's behavior was also unethical. The two most common reasons verbalized related to non-maleficence and fidelity. (See tables, page 29.)

"Our Ethics standard is not simply presenting points on how we interact with client, but also how we conduct ourselves in the full spectrum of professional contexts."

NON-MALEFICENCE (DO NO HARM)

Fact	Impact
Despite provision of training sessions and enthusiastic support of her employer, Narcy refused to use the new system. The result was that her patients on her caseload were at a disadvantage at the critical point of care transition.	• Narcy would not adapt her practice in order to facilitate transition planning. One of the ethical tenets at the heart of our standard is non-maleficence. • Narcy's failure to adapt to practice improvement caused harm to her transitioning clients, delaying their transitions by hours, and in some cases by a full day.

FIDELITY (TREAT OTHERS FAIRLY)

Fact	Impact
Narcy verbally harassed and insulted Margaret during live phone interactions and in voicemail messages. Margaret was anxious and apprehensive prior to all interactions with Narcy.	• Narcy's abusive behavior toward Margaret contributed to a poorly partnership. Margaret felt as if Narcy specifically targeted her; however, it was discovered that Narcy's behavior was similar with other plan case managers. • Margaret kept detailed documentation of all conversations and apprised her supervisor of all interactions. • The relationship between MHC and SGH had always been cordial and professional. Bi-monthly meetings focused on process improvement and review of extended lengths of stay case. Presently, meetings between the two organizations include a review of Narcy's conduct. MHC has no role in performance management of SGH employees.

The outcome of these sessions was that participants voiced a clearer understanding of how poor behavior equated to being both unprofessional and unethical.

Our Ethics standard is not simply presenting points on how we interact with clients, but also how we conduct ourselves in the full spectrum of professional contexts. We would all do well to consider our behavior and its impact on our peers, regardless of where we work within the care continuum. When one case manager makes a colleague's work life more difficult by failing to follow an accepted process or by using intimidation as a pressure tactic, we need to call it what it is — a failure to live up to our Ethics practice standard and a failure to be a *professional* case manager. ■

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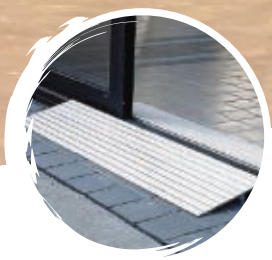

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