Case Management for the Win!

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Medical Case Manager
Mass General Brigham

Monday, March 25th, 2024
2:00-3:00pm

Principles of the Code of Conduct for Case Managers

This program has been pre-approved by the Commission for Case Manager Certification (CCMC) to provide

One Ethics continuing education credit to Certified Case Managers (CCMs).

Many or most of you in the audience here today are case managers. Some of you may or may not be certified by the CCMC. For those of us who are, we need to abide by the Code of Professional Conduct set forth and strictly enforced by the CCMC.

The following information is taken directly from the Commission for Case Manager Certification; we all know as CCMC.

www.ccmcertification.org

Revised April 2023.

CCMC defines case management as "a professional, collaborative, and interdisciplinary practice guided by the Code of Professional Conduct" (the Code).

The objective of the Code is to protect public interest. The Code consists of Principles, Rules of Conduct, and Standards for Professional Conduct, as well as CCMC's Procedures for Processing Complaints and Self-Reports.

The Principles provide normative guidelines and are advisory in nature.

The Rules of Conduct and the Standards for Professional Conduct prescribe the level of conduct required of every Board-Certified Case Manager (“CCM”). Compliance with these levels of conduct is mandatory.

CCMs who face ethical dilemmas regarding their own practice and/or ethical challenges that arise in the course of professional practice are encouraged to consult the Code frequently for advice.

CCMs recognize that their actions or inactions can aid or hinder clients in achieving their objectives.

PRINCIPLE #1: CCMs will place the public interest above their own at all times.

PRINCIPLE #2: CCMs will respect the rights and inherent dignity of all of their clients.

PRINCIPLE #3: CCMs will always maintain objectivity in their relationships with clients.

PRINCIPLE #4: CCMs will act with integrity and fidelity with clients and others.

PRINCIPLE #5: CCMs will maintain their competency at a level that ensures their clients will receive the highest quality of service.

PRINCIPLE #6: CCMs will honor the integrity of the CCM designation and adhere to the requirements for its use.

PRINCIPLE #7: CCMs will obey all laws and regulations.

PRINCIPLE #8: CCMs will help maintain the integrity of the Code, by responding to requests for public comments to review and revise the code, thus helping ensure its consistency with current practice.

CCMs understand that case management is guided by the ethical principles of:

- **Advocacy – promoting, recommending for client**
- **Autonomy – independent, self-govern**
- **Beneficence – positive action**
- **Nonmaleficence – to do no harm**
- **Justice – fairness and equality**
- **Fidelity – keep commitments or promises**
- **Veracity – report all facts accurately to all parties**

During this session, we will be providing several cases, including catastrophic and non-catastrophic, and identifying the ethical principles used in the medical management of these injured workers. Nearly every day, case managers are required to uphold these ethical principles when often faced with uncertainty, controversy, and subjective feelings and opinions.

We encounter an ethical dilemma and first and foremost need to consider what is best for the client. However, we may question the validity. We may be employed by the insurer. We may not agree with a treatment plan. We may not have faith in the medical provider. We may feel the compensability decision is morally wrong. We may learn there are barriers that are impossible to overcome. We may learn information that influences the case in a negative resolution. These are just a few examples of the dilemmas we encounter. CCMs must then remind themselves to consult with the Code for guidance.

Case Study 1: Low Back Pain

Rosanne Westcott RN, BSN, MA
VRS Disability Management

Case Study 1: Low Back Pain

- **History of Injury:** IW is a 45 yr. old male who injured low back on a call while working as Fire Inspector.
- **Treatment:** Initial: ED to Occupational Health – Treated conservatively with Medrol dose pk, muscle relaxer, PT, OOW – Severely impaired range of motion. Unable to straighten back.
- Referred to CM 3 months into treatment and no progress. Continued with LBP with bilateral hip and right foot issues.
- X-ray negative for fractures.
- MRI completed: Multilevel degenerative disc changes, Right lateral disc protrusion at L4-5.
- EMG Normal Bilateral LE.

Case Study 1: Low Back Pain

Prior to consult: IW did have LD release from Occupational Health: No lifting > 10 lbs. FCM did meet with Employer to address if able to accommodate and Job Site Assessment completed.

Consult Orthopedics: Determined not a surgical candidate.
Consult Physiatry:
Lumbar Spine Pain: Recommended series of 3 ESI injections:
First injection: 80% improvement; 2nd injection: 0% improvement; 3rd injection: 90% improvement.
Hip Pain: SI joint injection completed.
Outcome: RTWFD w/no restrictions. Ongoing recommendations:
Lifestyle changes/Yoga by Adriene.

Case Management Ethical Principles

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[Case 1] Select the primary ethical principle used within this case.

ⓘ Start presenting to display the poll results on this slide.

Case Study 2: Catastrophic Injury Degloving Right Hand

Catherine L. Reno, RN,BSN,MBA, CCM

Medical Case Manager

Case Study 2: Catastrophic Injury Degloving Right Hand

DEGLOVING – Soft tissue injuries involving separation of skin, Sq tissue from underlying fascia, muscle and/or bone

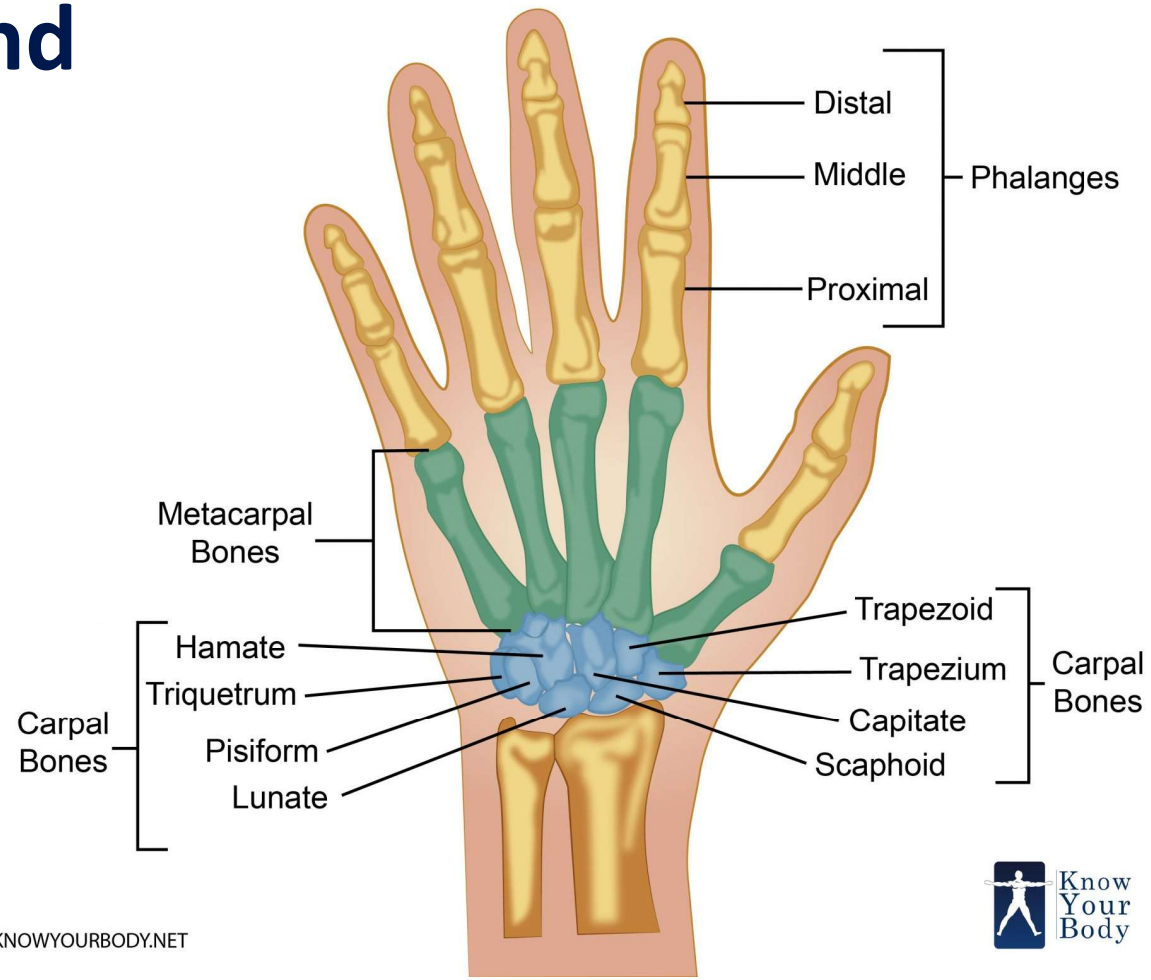
23 y/o worked for Insured 2 months providing maintenance of food processing machinery
1/11/19 Right hand got caught in conveyer resulting in skin, muscle and bone injuries Transported via ambulance to local trauma center for urgent ER/OR intervention

Case Study 2: Catastrophic Injury Degloving Right Hand

Underwent I&D Skin, soft tissue, muscle and bone: ORIF and pinning 1st metacarpal base:
2nd metacarpal neck; 1st, 2nd and 3rd CMC joints with complex wound closure – Discharged to home following day – Opiate use d/c Day 3

MD F/U 1/25: MD reported complex dorsal radial hand injury in addition to fractures, loss of tendons to index finger; significant loss of dorsal bone – Recommended Angiogram to ascertain blood flow to hand – CM provided authorization per prior discussion with adjuster

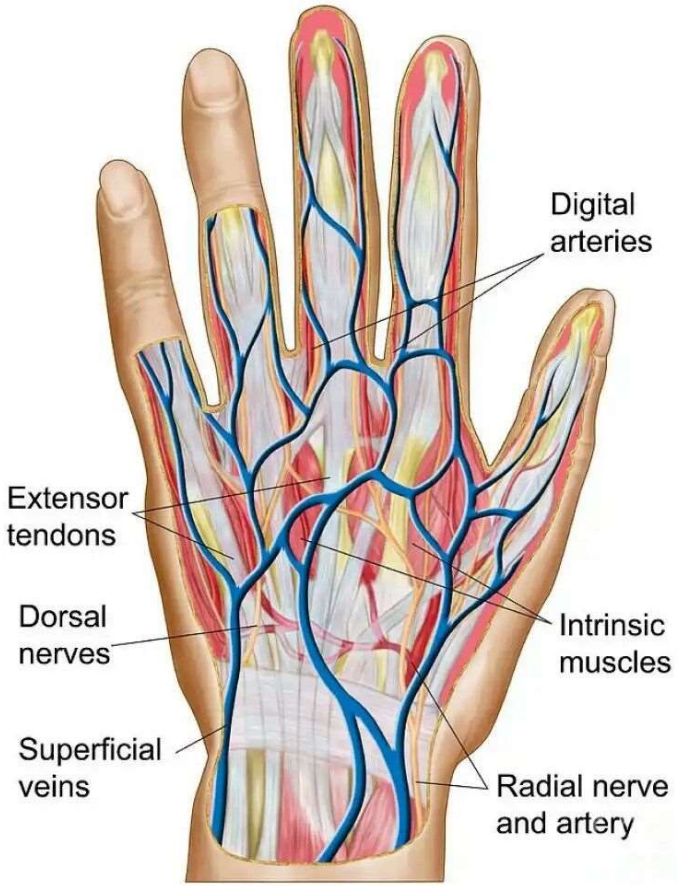
Case Study 2: Catastrophic Injury Degloving Right Hand



KNOWYOURBODY.NET

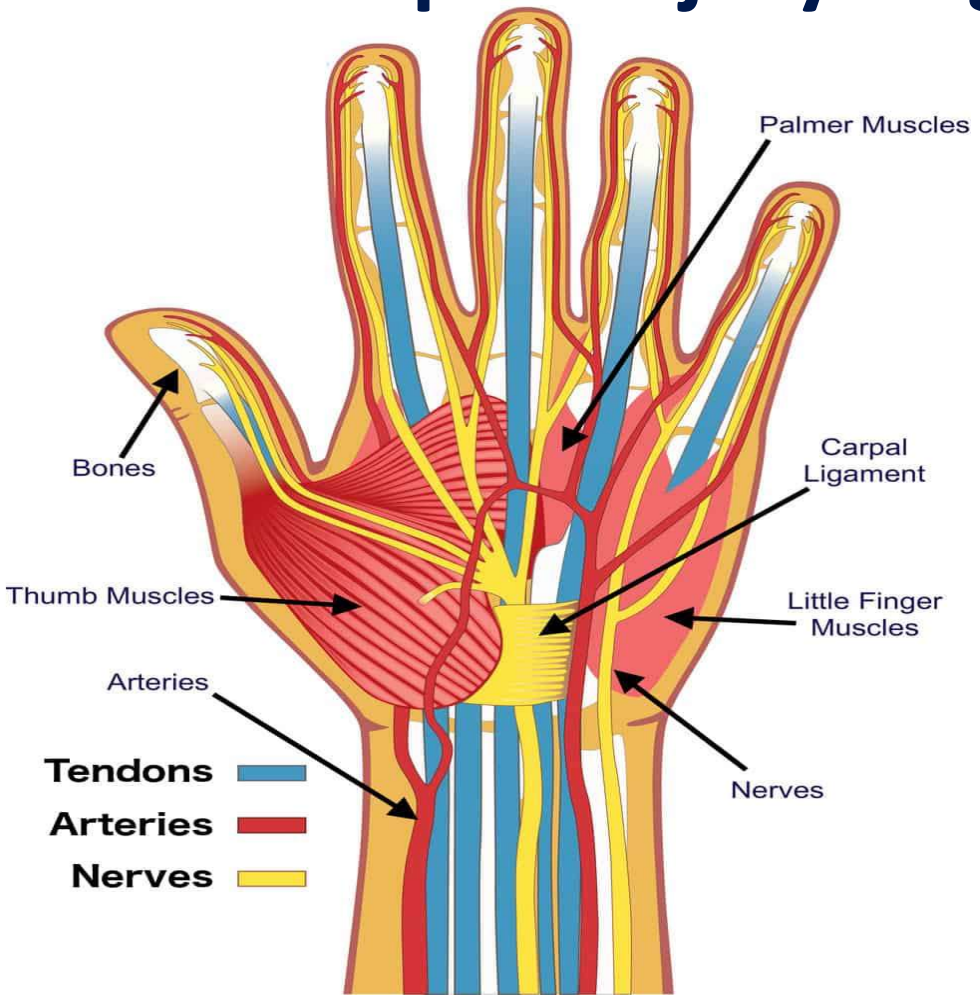
Know Your Body

Case Study 2: Catastrophic Injury Degloving Right Hand



Dorsal View Hand

Case Study 2: Catastrophic Injury Degloving Right Hand



Case Study 2: Catastrophic Injury Degloving Right Hand

- MD F/U 1/29: Angio not completed – MD reported did not know how to do orders (CM had MD write orders and expedited scheduling) Wound debrided – MD recommended Rad Amputation (amputation distal to the CMC joint) of the index finger – CM intervened recommending MD discuss in detail reason for recommendation
- Would reduce need for multiple surgical interventions to repair tendons, tissue and bones
- Would expedite recovery to about 200 days versus projected 600 days disability with extensive reconstruction
- Would eliminate non-functional digit which results in safety issues

CM suggested Home Care Services to facilitate improved wound care -MD refused indicating he did not know how to do it – CM offered to intervene to no avail

CM offered EE ability to obtain a second opinion as EE was averse to amputation

- MD F/U 2/8- Angiogram results indicate excellent blood supply to areas requiring reconstruction - MD did not debride wound - CM again requested Home Care Services to facilitate improved wound care with MD providing orders
- MD F/U 2/22 & 3/1 -Wounds were debrided - MD continued to recommend RAD amputation
- MD F/U 3/8 - Wound debrided - New plan of care offered Split Pedicle Groin Flap which EE was averse to
- Second Opinion at alternative Tertiary Center with Orthopedic Hand Service on 3/18/19 – followed by consultation with Plastic Reconstruction Surgeon on 3/25 with plan for dual surgery – Cannot guarantee index finger is viable but will make every effort to return hand to optimal function

- 4/12/19 OR - I& D wound, inspect tendons /blood supply and remove pins, D/C opiates Day 2
- 4/19/19 - Wound free from infection - OT visit same day per MD recommendation

- 4/26/19 - MD F/U- Wound healing /no infection
- 5/3/19 – Second Surgery – Reconstruction index finger with bone graft/DBX – D/C opiates Day 3
- 5/16/19 – F/u X-rays good alignment – continue casting finger exercises
- 6/10/19- F/U Ortho Plastics Re-xray of index finger metacarpal shows fusion with excellent alignment , EE very dissatisfied with OT provider – less than optimal quality of hands-on care; no enthusiasm/negative regarding plan of care, CM offered transfer of services, obtaining orders to facilitate same-day treatment to fabricate splint; Provide OT to hand, wrist, thumb, third digit and index DIP

- 7/1 and 8/2 - MD F/U - Pins removed, continue splint and OT
- 9/10/19 – OT decreased 1x week due to excellent response to date and family efforts with improved range of motion excluding the web space
- 10/21/19 - F/U - exhibits excellent mobility web space enabling ability to reattach tendons and graft as needed – Deferring web space and tissue defects – Surg scheduled for 12/19/19
- 1/2/20 - Surgery went well, all tendons were repaired, D/C opiates 3 days, to remain in splint 24/day to maximize blood supply - Ordered early OT intervention
- 2/5/20 - MD F/U - Excellent alignment, EE exhibits excellent ROM 4 fingers, ability to form fist with limited pinch index to thumb which MD's did not expect until 6 mo post op, Discussed potential need for mesh or pedicle groin graft to repair tissue deficits dorsal side web space, Assigned modified duty work capacity – no lifting right hand; 25 pounds with left, 4 - hour work days progressing to 8 hours as tolerated

- **3/2/20 - MD F/U - Doing well with work - now doing 8 hours – tolerating except when he bangs hand – MRA ordered to assess blood supply to thumb in preparation for plastic reconstruction**

- **3/9/20 - EE laid off from work due to Covid, RTW on 6/1/20 continued restrictions - Meanwhile continued with home exercise program**

- **MRA finally completed 8/27/20 - F/U MD's 9/14 – Excellent hand function with no need to consider RAD amputation index finger, MRA indicated no active radial vascularization with collateral ulnar vascularization indicating high risk for death of thumb and web space if they try to reconstruct dorsal area, EE requested a second opinion with Plastic Reconstruction Surgeon**

- **Second Opinion delayed due to continued Covid Restrictions and EE ability to take time off. Consult completed on 12/16/20 – Concurred with avoidance of reconstruction of dorsal tissue/fat loss – Recommended contracture releases with skin grafting to maintain web space mobility**

- **1/9/21 - After conferring with his family he deferred further surgery, willing to adapt use of hand /arm to perform ADL's – Hampered by pain in web space when he strikes the area and has tightness hampering his grip strength and endurance - all things he can currently live with per his report**

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[Case 2] Select the primary ethical principle used within this case.

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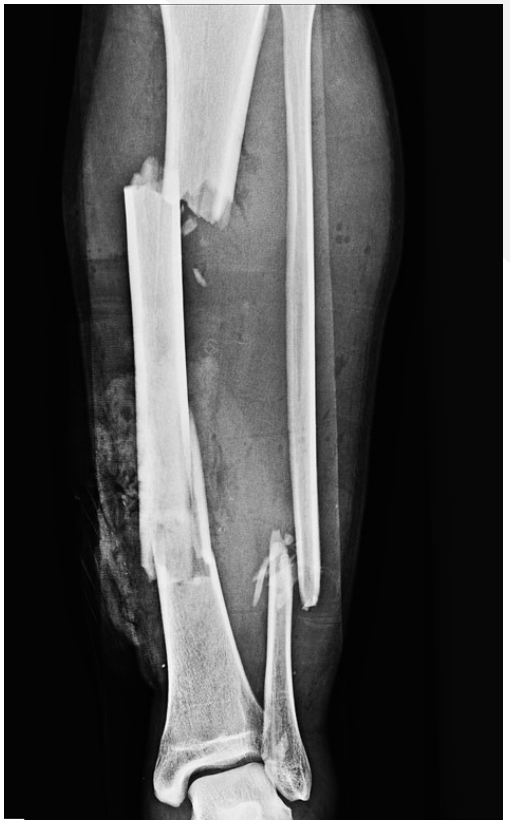
Case Study 3: Multiple Trauma

Cynthia Bourbeau, RN, CRRN, CCM, CNLCP®, CHLCP™

President/Founder of Medical and Life Care Consulting Services

Case Study 3: Multiple Traumas

- 48 year-old Male
- Construction Worker
- Fractured Tibia and Fibula with ORIF
- Compression Fracture Thoracic Spine
- Concussion



Case Study 3: Multiple Traumas Complicating Factors

1. Living Situation: Lived in a mobile home with his girlfriend and her children. (His Home) Day prior to this injury, patient had broken up with her. Was not allowed back into his own home. Did not want to push the issue as he was worried about her children. Emotional due to breakup.
2. Smoker of 30 years: One pack per day
3. Non-compliant with treatment: Non-healing fractures and wounds.
4. Alcoholic. Not verbally admitted to by patient but while treatment was underway, situation became apparent. Drinking alcohol while taking narcotics.
5. Inappropriate Behavior

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Thank you!