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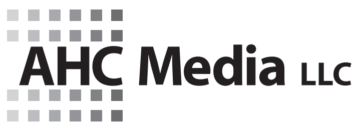

IN THIS ISSUE

■ Patient-centric care coordination decreases hospitalizations, ED visits . . . . cover

■ Telemonitoring, education slash hospitalizations for CHF, hypertension. 136

■ Depression program focuses on PCPs 137

■ Act now to strengthen ties with emergency services . 139

■ Reduce stress with a simple intervention 140

■ Competition is good when it comes to incentives 140

■ Health care tops in injuries on the job 141

■ **Inserted in this issue:**
— *2009 Index*

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Patient-centric care coordination decreases hospitalizations, ED visits

Program combines face-to-face, telephonic case management

A combination of face-to-face and telephonic case management has resulted in high patient satisfaction ratings and a significant decrease in health care utilization for patients with complex medical needs.

The care management program, provided by Alere, an Atlanta-based health management firm, resulted in a 38% decrease in hospital admissions, a 36% reduction in hospital days, and a 30% decrease in emergency department visits for patients who are members of one health plan, according to a 2007 study.

Alere's care management team provides care coordination for patients with life-limiting diagnoses or significant chronic disease.

About 60% to 70% of patients in the program have advanced cancer. Others have multiple comorbidities, such as heart failure, diabetes, chronic obstructive pulmonary disease, coronary artery disease, and hypertension.

Care managers live in the same community as the majority of the patients they support and carry a caseload of about 22 patients at a time.

"We limit the caseload because of the intensity of resources patients in the complex care management program need and the amount of attention they require," says **Albert Holt**, MD, MBA, senior vice president and senior medical director for case management and disease management programs for Alere.

The care managers conduct an initial assessment in the patient's home or hospital room and follow up by telephone. If there is a change in the patient's status or the patient is going to another level of care, the care manager makes another home visit.

If there isn't an Alere care manager nearby, the company sends a nurse case manager to that area to complete the in-home assessment.

The key to the success of the care program is taking a personal

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approach to care coordination and building a relationship based on face-to-face contact and working with the patients on goals that they identify as important, Holt says

"When the care managers go into the patient's home, they get patients' perspective on illness and what they want to achieve. They collaborate with the patients and family members to set goals based on what patients want to do and develop a plan to help them meet their goals. Because patients are engaged in their own health care, they are able to keep their conditions from getting out of control and avoid hospitalization or visits to the emergency department," he adds.

Alere identifies patients eligible for the program by screening claims, precertification, medical information, and other data from their insurance plan and employer group clients.

"We concentrate on precertification and immediate hospital data because we want to get patients when their illness is new to maximize our assistance to them," Holt says.

The organization's triage enrollment nurse calls eligible patients and completes an assessment to determine the client's clinical status and need for case management and enrolls interested patients in the program.

The care manager who is assigned the case sets up an appointment for a comprehensive in-home assessment that typically lasts several hours, says **Linda Alden**, RN, CCM, a complex care manager based in Southern California.

"We always encourage family members to be present when we meet with the patients. We're collecting and offering a lot of information, and it's always good to have more than one set of ears listening," Alden says.

The care managers already are familiar with the patients' medical history but they also find out the patients' perception of their disease process.

'Perception is reality'

"Perception is reality. We often have cancer patients who are recovering from surgery and don't expect to have to have chemotherapy or radiation because the surgeon told them they removed the tumor and the margins were clear. If we know what they perceive, we can start the educational process there," Alden says.

During the initial visit, the case manager completes an in-depth assessment of the patient's symptoms, resources, and support system, says **Nancy Messenger**, RN, CCM, a care manager based in Northern Michigan who coordinates care with indemnity patients, often traveling throughout the country to meet them in person.

"We want to get a full and total picture of the patients and their needs during the face-to-face visit. One of the joys about this job is the flexibility we have to give our patients personal service and do whatever is needed to meet their specific needs, whether it's financial assistance, education, transportation, or help with meals or housekeeping," Messenger says.

After the initial assessment, the care managers develop a dynamic care plan and discuss it with

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their nurse supervisor, called a clinical support manager, and their medical director.

All of the complex case management cases are reviewed twice a month by the medical director to provide additional support and keep the clinical guidance on track, Holt says.

"The medical directors keep on top of chronic diseases and oncology regimens and can call on specialty experts when needed. For instance, if a patient has a complicated diabetes regimen, they can call on a diabetes specialist for advice," he says.

At the time they open a case, the care managers send a letter to each of the patient's physicians introducing the case management program to them.

The care managers identify one physician who is the primary physician and collaborate with him or her. For instance, if the patient is undergoing cancer treatment, the oncologist is likely to be the primary physician.

"Our relationship with the treating physician is very important," Alden says. "Patients are on the phone with us for an hour at a time and talk to the doctor's office for five minutes. They tell us things that they don't share with the providers. We give them additional information to help them make clinical decisions."

Facilitate communication among physicians

Most of the patients in the program are being treated by multiple providers, most of whom do not regularly communicate with each other, Messenger adds.

"We facilitate communication among the treating physicians to make sure the patient's care is coordinated," she adds.

The nurses take a patient-centric approach to coordinating care, Holt says.

The complex care team treats the whole patient, not just the issues they are called in to address, Alden adds.

"We may be working with a cancer patient, but when we conduct the assessment, we find out he or she has hypertension. We incorporate education on managing hypertension, such as diet, exercises, and medication compliance, into our care plan for cancer," she says.

The care managers call their patients at least once a week and encourage them to call any time they need help.

"Because we're not a family member, a friend, or a physician directing their care, patients often feel more comfortable speaking with us. We can find out what's going on with them and alert their health care providers if needed," Messenger says.

That first face-to-face visit helps the care managers get to know the patients and their families and start to build a relationship.

"We become more than just a voice on the phone. We are alerted to safety issues when we visit the home, but we also find out what brings the patients joy. We can see their hobbies, pets, and family members and use that information to personalize our conversations instead of talking only about their disease or treatment," Alden says.

When patients have cancer, the care managers educate them on the possible side effects of treatment and how to overcome them.

Patients with cancer are undergoing active treatment and need support in understanding their options, learning what to expect from treatment, and how to coordinate their health care needs. Some are so far advanced that they are transitioning into the terminal stage, Holt adds.

"Almost every cancer patient tries to be as positive as possible, but they all have a day when everything seems to fall apart. Chemotherapy can be very debilitating. We try to keep them emotionally stable and encourage them to forge on ahead," Alden says.

Advance directives discussions key

The care managers bring up the subject of advance directives during the initial assessment and work with the patients and family members to ensure that they are in place.

"I always tell them that I recommend this to all my patients and that I have completed my own advance directives. I don't want them to think that I know something they don't know. I tell them that when they are ready, I can walk them through it," Alden says.

The care management organization has won awards for the care managers' successful discussions with patients about advance directives, Holt says.

"About 20% of our patients die during the course of complex case management, and more than 70% of them have advance directives documented," he adds.

When a patient's condition starts to deteriorate, the care manager starts discussing end-of-life issues and possible hospice care.

"Every case is unique, and everybody reacts to end of life in different ways. Because we know these patients so well, we know how to address it," Alden says.

Educating patients on advance directives and end-of-life options is a service to the patients, Messenger says.

For instance, one of Messenger's patients had a terminal diagnosis but didn't know about it.

"It wasn't my place to tell him so I steered him back to his physician to have the conversation when I determined that he wanted to know," she says.

She spoke to the patient as he was leaving his physician's office, stunned by the news.

"I asked if he was alone and if he was OK to drive. The next time he saw me, he thanked me. By finding out about his diagnosis, he had time to make advance directives and put things in place for his family," she says.

Patients stay in the program as long as they need assistance. Patients undergoing cancer treatment usually stay in the program until they are well educated and have met their goals.

"We make sure they are very clear about their follow-up regimen and all the health care screenings they need to have," Messenger says. ■

Telemonitoring, education slash hospitalizations

Nurses work with patients in home, monitor remotely

Bayada Nurse's program that combines face-to-face education and remote monitoring of clinical information reduces hospitalizations for patients with congestive heart failure and hypertension.

Patients with congestive heart failure who participated in the remote monitoring pilot program experienced 59% fewer hospital visits than a control group of patients with the same condition who received only the education component of the program, according to **Brian Farber**, MBA, MA, director of the telehealth program.

Hospital visits were reduced by 40% for patients with hypertension.

Bayada Nurses, with headquarters in Moorestown, NJ, provides home health nurses and home health aides in 18 states and the United Kingdom.

The home care agency conducted a pilot project using the telemonitoring equipment in 2007 and achieved excellent clinical outcomes, including the reduction in hospitalizations, Farber says.

"Based on the success of the pilot, we are expanding the program throughout the company," he adds.

Patients in the program measure their weight and blood pressure daily using a Bluetooth-enabled digital weight scale and a blood pressure monitor. The wireless devices automatically send timely data to telehealth nurses who monitor them seven days a week.

"Right now, there is no reimbursement for telehealth, but we decided to implement the program because of the good outcomes. By investing in the program, we're hoping that insurance companies can see the benefit and authorize reimbursement for it," Farber says.

Telemonitoring saves money

Preventing just one hospitalization can save as much as $30,000, Farber points out.

"Remote monitoring is going to be an important component of patient care in the future. It provides real-time data that indicate when a chronic disease is exacerbated and enable the health care provider to make adjustments, saving a trip to the emergency department or a hospitalization," he says.

The system saves expenses because the nurses don't have to make a home visit to check the patient's vital signs and patients don't have to go back to the doctor's office as frequently, he adds.

Patients in the program have advanced chronic diseases, such as congestive heart failure, hypertension, diabetes, or, most likely, a combination of diseases.

"This is not a typical telephonic disease management program. We go to the clients' homes and help them learn to manage their disease face to face in conjunction with their physician. By using telemonitoring, we are able to monitor their vital signs and other information seven days a week and identify any exacerbations that are occurring before they become acute," Farber says.

Eligible patients are identified when they are experiencing acute exacerbations, are referred by physicians, or recently have been discharged from the hospital and need help learning how to manage their condition and receive a home visit from a Bayada nurse.

"Once the patient is stable, the nurses start

assessing their chronic diseases and their need for support in adhering to their treatment plan and keeping their condition under control," he says.

When the Bayada home health nurses identify a patient who may be eligible for the telemonitoring program, they contact the patient's physician and get permission for the telemonitoring to be part of the patient's plan of care.

The nurse schedules a visit to introduce the patient to the service and to demonstrate how to use it.

On each visit to clients' homes, the nurses follow a protocol that includes specific teaching points. For instance, they educate congestive heart failure patients on what foods to avoid, how to recognize signs that their illness is exacerbating, and when they should call the doctor.

The nurses develop a close relationship with the patients, listen, and identify the time that they are most ready to hear the message about making changes to manage their conditions.

"When someone has a chronic disease and is doing well, they aren't very open to education. But once someone's disease state starts to exacerbate and they're not feeling well, they are open to education at that exact point. The nurses teach whatever the patient is ready to learn. If the patient hasn't absorbed the last lesson, they repeat it," he says.

The goal of the program is to help the clients take ownership of their own disease process.

"We can't be with them all the time so they need to learn to manage the disease on their own," Farber says.

The nurses schedule at-home visits based on the patient's condition and the information received on the telemonitoring device. They communicate with the patients by telephone at regular intervals and make home visits when needed.

Telemonitoring doesn't replace face-to-face visits by the nurses, but it enables them to maximize their time and manage a larger caseload.

"Because we are monitoring the patients seven days a week, we can determine if we need to visit. If the nurses and the patient are working well together and getting the patient's condition under control, there is no need to send a nurse out there. Instead, we can send the nurses to see someone else where it is more appropriate," he says.

When the nurses see patients developing problems, they work in conjunction with the physician to get the patient back on track.

In some cases, it might be as simple as reminding the patient to change his or her eating habits. Other times, the physician may adjust the medication.

For instance, if a congestive heart failure patient has gained weight, the nurse will ask what he or she ate the day before and may determine that a salty food is causing the weight gain.

Since the nurses are getting objective data every day, they can work with the physicians to help them make more informed decisions.

For instance, if a patient has an appointment with his or her physician, the nurses can provide three weeks worth of daily biometrics on which the physician can base treatment decisions.

"We believe if we monitor patients daily, we have a better chance of helping them keep their condition under control and increasing their quality of life," Farber says.

For instance, the monitoring data may show that a patient with hypertension has a spike in blood pressure. The nurse passes the information on to the doctor, who may make a change in the medication, stabilizing the patient's blood pressure.

The average patient stays in the telemonitoring program for 60 days, longer if they need more support.

"The clients feel a sense of comfort because someone is looking out for them. Sometimes a call from the nurse is the only communication a client gets that day," Farber says.

(For more information, contact: **Brian Farber**, Bayada Nurses, bfarber@bayada.com.) ■

Depression program focuses on PCPs

Plan aims to identify disease, help patients manage

Recognizing that more than half the population with depression is treated in the primary care setting, MercyCare Health Plans developed a depression disease management program focusing on giving primary care physicians the tools they need to be able to recognize and treat depression.

"Despite a high prevalence of the disease, depression remains undiagnosed and undertreated, says **Linda I. Hanson**, RN, CCM, who helped develop the depression program and works with patients who are identified with

depression. “If people have chronic conditions such as asthma, diabetes, or heart conditions, the probability of depression is high. We started the program to make sure our health plan isn’t missing opportunities to help people feel better and stay well.”

MercyCare Health Plans is a subsidiary of Mercy Health System serving about 32,000 members in Southern Wisconsin and Northern Illinois. The health plan has a network of more than 600 credentialed practitioners and six hospitals.

“According to the NCQA [National Committee for Quality Assurance], between 40% and 50% of primary care patients being treated for depression stop taking their medication within three months of diagnosis. Patients who discontinue their depression medication within six months incur an average of $400 more in medical costs per year than patients who are adherent to their depression treatment plan,” she adds.

The goal of the program is to identify patients with depression and work with them and their physicians to promote adherence to medication management and improve health outcomes in keeping with the latest standard of care, she adds.

The depression program was developed by a multidisciplinary team of network practitioners including a pharmacist, a data analyst, and a quality coordinator. Hanson facilitates quarterly meetings of the team during which they continue to review and refine the program.

The team started by identifying a depression screening tool, the Patient Health Questionnaire-9 (PHQ-9), to use to evaluate patients and their progress. They created a way to get information from claims data when people fill prescriptions for antidepressants.

“One of the challenges in identifying members with depression is that analyzing claims data is like throwing out a big net. Antidepressants are sometimes used for smoking cessation and other conditions, and those people show up in our data as well,” she says.

Another challenge is getting members to buy in to the program because of the stigma connected with mental health disorders, she adds.

“This is an opt-in program, which means people have to agree to be a part of it. Some patients don’t like the idea of being recognized as having depression,” she adds.

When Hanson gets a list of patients who have filled a prescription for an antidepressant, she sends them a letter that says their records show that they are taking a medication that may have been prescribed to treat depression, and that if depression is why they are taking the medication, the health plan can help.

When members receive the letter, they have two options: They can use the self-addressed stamped envelope asking for more information or they can call Hanson directly.

After she gets the member’s consent to participate in the program, she introduces the program and what it hopes to accomplish.

She conducts a detailed assessment that includes information on the patient’s social support, financial status, other medical conditions and concerns, and other stressors in their lives, as well as the PHQ-9 depression severity screen.

When Hanson talks with patients, she spends most of her time listening and assessing the patients’ readiness to change their behavior to become more adherent to their treatment plan.

“The patients need to be ready to change. I could talk to them every day for two hours and if they’re not ready to change, no intervention will help them,” she says.

She addresses barriers to compliance and helps the patients work to overcome them.

“By the end of the conversation, we’ve figured out what we need to work on. I take it in small steps and pick one thing to concentrate on. We come up with a plan to help the patient meet his or her goal,” she says.

Hanson and the patient work together to formulate self-management goals and agree on the frequency of telephone visits.

“I let them know that I will be calling their provider and that the three of us will work as a team,” she says.

In the beginning, Hanson talks to most of the patients weekly, and some every day if needed. She works with the patients to take small steps toward meeting their goals.

For instance, one patient who had multiple comorbidities wanted to start meditating but felt overwhelmed about starting it.

“By the end of the conversation, she had talked herself into closing her door and looking at a picture of the ocean. It’s simple things like that. Patients with depression get so easily overwhelmed that they don’t take the time to try things,” she says.

She works with the patients on the importance of staying on their antidepressant, exercise and nutrition, as well as coping and learning how to relax.

"It's teaching and talking on the phone that's most effective in changing behavior. I can send them hard copies of the resources available to them but they aren't likely to use them," she says.

When she sends them information, she tells them to put it by the telephone so they can refer to it during the next conversation.

She typically works with patients who have depression for nine months to a year until they are ready to self-manage their conditions.

"I let them know right away that I won't be working with them forever, and I tell them in advance when I'm moving them toward self-management," she says.

She sends the provider a letter notifying him or her that the patient opted in to the program and includes her business card, depression guidelines, and refers the physician to the health plan's web site.

"Most of the time when I call, I talk to the nurse or the medical assistant. I'm always willing to talk to the providers when they have time. Many of them don't know this program is available," she says.

Hanson has spent a lot of time reaching out to the primary care physicians in the network, informing them about the program and the information that is available to help them manage their patients.

"The majority of patients are not recognized as having depression. We let them know that there is a tool that they can use to screen their patients," she says.

One of the team's achievements was getting the PHQ-9 screening tool available to the primary care physicians in the electronic medical record for Mercy Health Systems.

"We want to have it as a pop-up for them to help them remember that if they ask the first two questions on the tool and patients answer positively that they should screen them for depression," she says.

The tool asks patients: Over the last two weeks, how often have you been bothered by any of the following? The first two topics are: little interest or pleasure in doing things and feeling down, depressed, or hopeless.

As part of her outreach program, Hanson visits the primary care clinics in the area to get to know the staff and the physicians.

"I work to build professional relationships with the physicians and nurses. If they don't have the name and know the face of a case manager, they aren't as likely to refer patients," she says.

Hanson is working on integrating the depression program with the health plan's complex case management program.

"People with complex medical needs benefit from the same type of interventions as patients with depression. Unlike in other disease management programs, these conversations can be a minimum of 30 minutes, and some last nearly two hours," she says.

*(For more information, contact: **Linda I. Hanson**, RN, CCM, depression case manager, MercyCare Health Plans, e-mail: lhanson@mhsjvl.org.)* ■

Act now to strengthen ties with emergency services

When a serious motor vehicle accident occurred at Detroit, MI-based General Motors Corp.'s Milford Proving Ground location, a life flight helicopter was on site less than 10 minutes after the incident. **Joel R. Bender**, MD, PhD, MSPH, FACOEM, the organization's corporate medical director, credits this response with the "very strong relationship established with the local emergency services providers."

"Had this relationship not existed and the employee been evacuated via ground transportation, the critical treatment that the employee required would have been delayed," says Bender. "Just getting an ambulance to the correct location presents a challenge at this site due to the fact that it covers an area of greater than six square miles, with 135 miles of roads and 126 separate buildings."

It's not something the occupational health manager utilizes in day-to-day operations, but in the event of an emergency, the relationship — or lack of one — established with local emergency services providers suddenly becomes crucial.

"At General Motors, we strongly encourage building relationships with local emergency providers for a variety of reasons," says **Patrick Stover**, MD, senior medical director at General Motors Corp. "The availability and connection to community resources is considered a critical component of the pre-hospital plan of action." He recommends the following steps:

• **Arrange on-site visits with your local fire and police departments and paramedics.**

Depending on the location of the worksite

emergency, providers may need to contend with multiple entrances, difficult access points, moving assembly lines, or deafening background noise. "In an emergency situation, this has the potential for the delay of administering what could be life-saving measures," says Stover. "Onsite visits allow providers to consider the best means for addressing these challenges."

• **Consider the need for airlifting serious injuries.**

At some of General Motors' locations, Federal Aviation Administration (FAA)-designated helicopter landing areas are used for this purpose. "Locations with these services have necessitated building relationships with the FAA and the airlift service provider," says Stover. "This includes a requirement that the airlift service provider participate in on-site training activities on a yearly basis."

• **Do table-top exercises at least annually.**

General Motors' Emergency Response Coordinating Team members work with community emergency responders during drills involving responses to mock incidents. "This ensures smooth integration with community entities in the event of an actual emergency," says Stover.

The exercises determine if the correct resources are available and highlight areas that need improvement. "A tornado devastated an Oklahoma manufacturing site a few years ago, but countless lives were saved because in the week before the disaster the site had conducted a live exercise on how to respond to severe weather conditions such as a tornado," says Stover. ■

Reduce stress with a simple intervention

Clear your mind…the rest will follow

A mindfulness-based stress reduction intervention, shortened so it could be done in the workplace, was done on healthy employees for a six-week period, with researchers measuring salivary cortisol each week. They discovered that this simple intervention significantly reduced stress and aided sleep for workers.[1]

Maryanna D. Klatt, PhD, the study's lead author and an assistant professor of clinical allied medicine at Ohio State University in Columbus, says she was not surprised with the positive outcomes. "I know the difference that mindfulness has made in my own life. But I was surprised by the sleep outcomes," she says. "If people are truly getting to sleep faster, and are more awake during the work day, then this was better than I hoped for!"

Klatt says that she is convinced that most working people could benefit from a way to "restructure how they experience stress, and that is exactly what mindfulness does. The 'low-dose' version enables real people to take advantage of the benefits that mindfulness affords."

Klatt adds that occupational health professionals can take advantage of this intervention themselves to reduce stress. She is currently planning a study involving nurses who need some strategies to help themselves stay healthy. "It is so common for caregivers to put their own needs last. This program helps people recognize the importance of valuing your own health," she says.

To teach this to employees, you would need to receive training in mindfulness-based stress reduction. However, Klatt says that the cost of the program itself is minimal, consisting of the cost of paying a teacher for the brief weekly sessions. "It is low cost for sure. The yield here is just wonderful for the cost," says Klatt. "To me, that is the strength of the approach."

Reference

1. Klatt MD, Buckworth J, Malarkey WB. Effects of low-dose mindfulness-based stress reduction (MBSR-ld) on working adults. *Health Educ Behav* 2009; 36 (3):601-614. ■

Competition is good when it comes to incentives

At Carolinas HealthCare System, employees can save $200, $400 or $600 annually by meeting up to 10 wellness criteria, such as exercising regularly, using seatbelts, or avoiding tobacco products. The program is part of the LiveWELL Carolinas initiative, and more than 25,000 eligible employees were entitled to register. "We had a preliminary goal that 26% of our population would register and take the online health questionnaire. We actually had 41%," reports **Mary Jane Rink,** RN, AVP of the Carolinas program.

A total of 1,171 employees signed up for LiveWELL Warriors, a six-month, intensive weight loss/lifestyle modification program that only accepts employees with a body mass index of 30 or greater. In a recent class of 302 workers, 105 completed the entire program and lost an average of 21 pounds. The group also made other healthy changes, with 54% eating fast food for breakfast less often, and 28% drinking fewer sweetened beverages.

Here are four reasons the organization got such good results:

1. It's easy for workers to participate.

Previously, employees came to the central office in the main facility. Now specialists advertise the hours they'll be at each location, for all three shifts. "Our program has evolved from being centrally located, expecting employees to come to us, to a more strategic 'deployment' of our wellness specialists out to over 15 locations," says Rink.

2. The programs are customized.

"Standard" programs for weight loss, walking clubs, lunch & learns, and wellness assessments are provided at all sites. "But as the specialist becomes more familiar with the unique culture of every site, he or she customizes the offerings," says Rink. "Through a series of brainstorming meetings, focus groups, and surveys, we have been able to determine what employees want versus what we say they need."

It turned out that employees wanted help with stress-related issues — specifically, a quiet place to escape for a minute during the shift and massage therapy on the units. "We did pretests to measure perceived stress levels, and plan to do post-testing for follow up," says Rink.

3. "Champions" are used to promote the programs.

Rink says that one of the best things you can do when getting a program started is to identify "leaders that employees admire. Enlist their help in getting something small started." Rink met with every administrator at every location, and his or her leadership team. "These folks identified employees whom they thought would like to get involved," she says. "We met with these identified employees, who spread the word to others they know, in a grassroots fashion." To reward the champions, a LiveWELL calendar was published with many of their stories and photos, and they receive a free LiveWELL cookbook of recipes from employees.

4. Friendly competition is encouraged.

Quarterly wellness challenges are held, with prizes going to the winning teams, and winners posted on the hospital's web site. "We go to the departments with a basket of healthy goodies, and have a small celebration to grab some attention," says Rink. "Ours is a competitive group."

The "challenges" are usually tied to an event the hospital system is sponsoring. For example, the next event involves a benefit for the Levine Children's Hospital. The hospital has partnered with a local running company to create training plans for employees who have never run, or for those who want to improve their times.

A large trophy goes to the vice president whose division hosts the winning team, and the department gets to keep it for the quarter. "We have regular leadership meetings that are well attended," adds Rink. "We present the trophy, Emmy awards style, to the VP. That really gets the competition going!" ■

Health care tops in injuries on the job

New push for safe patient handling law

Being a nurse's aide or orderly is the most injury-prone job in America. Those aides are four times as likely to be injured on the job as the average worker, and their rate of injury tops freight haulers and handlers, and construction laborers. It is more hazardous to lift patients than it is to hoist crates or move furniture because many hospitals and long-term care facilities still do not have adequate lift equipment, safety experts say.

The resulting musculoskeletal disorder (MSD) injuries boost the injury tally for general medical and surgical hospitals to the top. They reported 268,800 injuries in 2007, according to the U.S. Bureau of Labor Statistics (BLS) — the highest total of any industry group. While it would be reassuring, at least, if injury rates were declining, the evidence of that is slight. The overall downward trend in work-related injuries is mostly due to changes in record keeping, according to an analysis of BLS data.

"There's an epidemic of health care worker injury in the United States, even with the data we've got — even if you don't correct the inconsistencies in the BLS data," says **William**

Charney, DOH, a national occupational health consultant based in Newfane, VT, and author of *The Handbook of Modern Hospital Safety* — Second Edition (CRC Press, 2009). "One-tenth of the work force files a workers' compensation claim every year," he reports.

To combat the greatest source of injuries in health care, a coalition has formed to support the federal Nurse and Health Care Worker Protection Act of 2009, or HR 2381. It follows a stream of state laws. In August, Illinois became the 10th and most recent state to enact legislation related to safe patient handling. The Illinois bill, which becomes effective on Jan. 1, 2010, requires hospitals and nursing homes to conduct risk assessments and develop strategies to reduce patient handling injuries. State-by-state efforts have built momentum, but a national law is necessary to create consistency and spur a U.S. Occupational Safety and Health Administration standard, says **Marsha Medlin**, RN, MPA, founder of the Coalition for Health Care Worker and Patient Safety (CHAPS), president of Safe Lifting Solutions, a consulting firm based in Mechanicsburg, PA, and director of medical products for Ergolet, a patient handling equipment manufacturer based in Minneapolis.

"Historically, I have been against legislating things that should be common sense," says Medlin, who also is a former hospital CEO. "But [progress] has been so slow. We can't let another health care worker suffer a disabling injury. It's up to us to protect them."

Proponents of the new legislation are making their case with data, scientific evidence, and personal stories. They assert that voluntary adoption of safe patient handling has been too slow. In the top 10 occupations with the most injuries and illnesses that involve days away from work, nurses' aides rank third and registered nurses rank 10th. A 2006 Washington state study found that MSD injuries were costing the state's hospitals and nursing homes $32.8 million a year, and that the workers' compensation claims rate was almost four times higher than for general industry.[1] When Medlin was vice president of clinical services for a system of about 60 hospitals, she examined the workers' compensation data and discovered that about half of the claims were related to patient handling. She became a proponent of safe patient handling programs, equipment, and training.

Medlin also spoke to injured nurses, which she says was a "humbling experience. They're angry, they're confused, they need help." Medlin herself developed a ruptured disc during a 25-year career, which began as an ICU nurse.

A patient handling standard?

The Nurse and Health Care Worker Protection Act would require the U.S. Occupational Safety and Health Administration (OSHA) to create a patient handling standard, much the way the Needlestick Safety and Prevention Act triggered a revision of the bloodborne pathogens standard. Health care employers would be required to maintain a safe patient handling and injury prevention program, including risk assessment and hazard identification, and "to purchase, use, maintain, and have accessible an adequate number of safe lift mechanical devices." The act also provides for reporting of injuries, training of health care workers, and an annual evaluation of the program. "Some people have asked whether this was an effort to raise the ergonomics standard again. This is not about ergonomics," says **Anne Hudson**, RN, a back-injured nurse from Coos Bay, OR, who founded WING USA (Work Injured Nurses' Group), a strong advocate of the legislation. "This is about removing disastrous lifting from the backs of health care workers."

The American Hospital Association has opposed the bill as being too restrictive. "Though well intentioned, the measure contained unreasonably strict guidelines that could jeopardize — and even prevent — proper patient care," the AHA said in a position paper.

Health care employers often have the misguided notion that patient safety is a higher priority than employee safety, says **Lynda Enos**, RN, MS, COHN-S, CPE, nursing practice consultant/ergonomist with the Oregon Nurses Association in Tualatin. In fact, employee safety also enhances patient safety, she says. The bill provides a framework and an important mandate, she says.

"It's broad enough so it gives the employer some choice as to how they tackle the problem," she says. Politically, it has been overshadowed by health care reform, but proponents point to the coalition as a sign of coordinated support. "No one has listened to us until recently. That's what's changed for us," says **Genevieve Gipson**, RN, Med, RNC, director of the National Network of Career Nursing Assistants in Norton, OH. "Nursing assistants have been talking about this for years."

With no ergonomics or patient handling stan-

dard, OSHA enforcement to reduce the hazards has been minimal. In April 2002, then-U.S. Secretary of Labor Elaine Chao announced a "four-pronged" approach to ergonomic hazards that would include enforcement under the "general duty" clause in the Occupational Safety and Health Act that requires employers to keep their workplaces free of "recognized hazards that are causing or are likely to cause death or serious physical harm." Only 13 citations had been issued to nursing homes or personal care facilities through September 2009 although in 2007 alone, 24,340 suffered MSD injuries that required days away from work. Because the injury rates in nursing homes would have triggered a "disproportionately" high number of inspections under the annual Site Specific Targeting program for high-injury workplaces, OSHA has limited those comprehensive inspections. The cutoff rate of "days away from work, restricted work activity, or job transfer" that triggers the inspection will be 17, compared to eight for manufacturing sites and 15 for nonmanufacturing sites. Three hundred nursing homes will be inspected under the program, a significant reduction from 392 such inspections conducted in 2008.

Meanwhile, NIOSH is trying to focus attention on the hazards of the Health Care and Social Assistance sector through its National Occupational Research Agenda (NORA). "Everybody thinks health care is a safe environment because you're taking care of people, but health care [workers] face many of the hazards that people face in industrial settings," commented **Teri Palermo**, RN, public health adviser and coordinator for the Health Care and Social Assistance sector at NIOSH in Morgantown, WV.

Specifically, NIOSH is promoting safe patient handling as a part of the curriculum in nursing schools and seeks to link health care worker safety to better outcomes for patients. For example, safe patient handling may mean fewer skin tears and less risk of dropping patients, says Palermo. In the NORA, NIOSH set a goal of decreasing strains and sprains that lead to days away from work by 25% by 2016. NIOSH also hopes to promote a greater safety culture in health care. "A particularly important need is to overcome the misconception that it is appropriate, acceptable, or necessary to risk [health care and social assistance] worker safety and health while treating patients. On the contrary, improving HCSA worker safety and health leads to improved patient safety," NIOSH stated. ■

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COMING IN FUTURE MONTHS

- New opportunities for case managers
- How to fight the obesity epidemic
- Coordinating care throughout the continuum
- Helping the elderly stay safe at home

CE questions

21. Alere's care management program has resulted in a 22% decrease in hospital admissions.
    A. True
    B. False

22. The average patient stays in Bayada Nurse's telemonitoring program for how long?
    A. 30 days
    B. 50 days
    C. 60 days
    D. 90 days

23. Linda I. Hanson says, according to the National Committee for Quality Assurance, how many primary care patients being treated for depression stop taking their medications within three months of diagnosis?
    A. between 20-30%
    B. between 40-50%
    C. between 50-60%
    D. between 70-80%

24. Which is recommended for relationships with local emergency services providers?
    A. Give local providers the opportunity to evaluate worksites.
    B. Arrange on-site visits only for particularly challenging worksites.
    C. Work only with internal employees for tabletop exercises.
    D. Avoid using scenarios involving severe weather conditions for mock incident response drills.

Answers: 21. B; 22. C; 23. B; 24. A.

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

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 **this** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

2009 INDEX

Case Management ADVISOR™

Covering Case Management Across The Entire Care Continuum

Behavioral Health
Guideline-based care, JUN:70
Identify depression early on, SEP:209
Program focuses on primary care: DEC:137

Business Issues
Collect data to justify your position, AUG:94
Demonstrating ROI, JAN:8
Look to reinsurer on difficult cases, APR:41
Prepare realistic occupation health initiative, APR:46
Productivity savings formula, JAN:9
Proving value without ROI data, JAN:7

Care for the Uninsured
CMs connect patients with PCPs, JAN:4
Follow up avoids readmissions, JAN:6

Community Case Management
Face-to-face interventions for chronic illness, MAY:55
Helping geriatric patients stay healthy at home, JUL:73
Medically frail stay safe at home, AUG:89
Working with employees in the home, JUL:75

Coordination of Care
Care through the continuum, MAR:27
CMs provide continuity of care, OCT: 112
DM, CM collaboration, JAN:1
Guided Care Nurses help chronically ill, NOV: 121
Health plan, MDs collaborate in pilot, OCT:209
Integrating coaching with health plan programs, APR:41
Medical group places CMs in hospital setting, MAR:25
Patient-centric care improves outcomes, DEC:109

Cultural Competency
Be aware of patients' beliefs, SEP:99
Diversity training for CMs, SEP: 101

Disease Management
Addressing barriers to self-management, OCT:177
Cutting medication costs for hepatitis C, FEB:17
Encouraging self management, OCT:115
Gearing programs to meet individual needs, JUL:76
Home-based chronic care model, FEB:13
Monitoring home health patients, DEC:136
Increasing participation in employee programs, SEP:105
Remote monitoring cuts cost of care, NOV:124

Geriatric Care
Demo project improves outcomes for dual eligble, MAY:53
Faith-based programs for Medicaid members, FEB:19
Sensitivity training helps staff understand, MAR:28

Health Literacy
Ensure that patients understand, AUG:85
Health plan addresses literacy, AUG:87

Health Promotion
100% of employees reached, SEP:106
Coaches encourage lifestyle changes, MAY:52
Co-workers promote wellness knowledge, AUG:94
Custom programs keep employees healthy, JUL:75
Helping chronically ill stop smoking, JUL:82
iPhone app helps in smoking cessation, JUL:82
Keeping employees healthy, FEB:16
Rewards for healthy behavior, MAY:51
Take proactive approach to wellness, MAY:49
Telephonic counseling for weight loss, MAR:35
Weight loss programs popular, JUN:71
Wellness program focuses on weight management, JUL:81

Medicaid Issues
Outreach identifies chronically ill, APR:37
Plan focuses on HEDIS measures, MAY:65

Patient Education
Addressing diabetes with a photonovela, FEB:22
Base discharge education on patient perception, APR:44
Film educates Latinos on home health, SEP:103
Identify barriers to patient adherence, APR:43
Photonovelas capture patients' attention, FEB:19
Photonovela teaches good nutrition, FEB:21
Support group provides continuing education, NOV:129

Preventive Measures
Addressing metabolic syndrome, JUL:80
Educating clients to avoid H1N1, JUL:77
Helping members at risk for chronic illness, JUN:63
Keep antiviral medications on hand, AUG:93
Pay workers for better health, NOV:129
Training parents on childhood disease, AUG:91

Professional Development
Case managers in the spotlight, SEP:97
CCM exam now online, JAN:4
CM Week is educational opportunity,

OCT:114
Mentors help staff learn their duties, JUN:61

Safety Issues

Free safety training available, AUG:91
Health care workers with H1N1, AUG:92
Incorporate sleep issues into wellness programs, MAR:33
Track needlestick benchmarks, MAR:32

Occupational Health

Avoiding panic about H1N1, JUL:79
Act now to strengthen ties with emergency services, DEC:139
Changes that help shift workers, MAR:34
Competition is good when it comes to incentives, DEC:140
Create a place of safety, OCT:118
Dealing with malingering, JUN:69
Employees going to India for surgery, MAR:34
Fragrance-free workplace, JAN:9
First responders save lives, NOV:127
Fit-for-duty evaluations, JAN:11
Health care tops in injuries on job, DEC:141
Helping maximize productivity, AUG:95
Information on workers' comp, MAY:57
IVP screening may not pay off, OCT: 119
Make sure wellness plan is appropriate, APR:44
Medical emergencies in the workplace, NOV:126
Nurses play big role in savings, MAY:58
Reduce stress with a simple intervention, DEC:140
Reducing workers' comp claims, SEP:103
Reward employees for near misses, SEP:106
Saving the lives of employees, NOV:128
Take a bigger role in workers' comp, MAY:56
Think before helping with surveillance, JUN:68
Three types of workers' comp plans, MAY:58
Use success stories to avoid cuts, JUN:67
Wellness program changes workers' lifestyles, FEB:30
Workers ID the cause of accidents, FEB:31
Worksite weight loss programs, JAN:10