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Professional development

It's time the public understood case management, experts say

Here's how and why you need to build your public image

You are the health care industry's best-kept secret. After nearly two decades of improved patient outcomes and advocacy, most Americans and even some physicians don't know what case management is, say public relations and case management professionals interviewed by *Case Management Advisor.*

Perhaps even more disturbing, recent reports in consumer magazines, newspapers, and national television news broadcasts have misrepresented the role of the case manager to your patients and customers. "We as case managers do an excellent job of advocating for our patients but have not done a good job advocating on behalf of ourselves," explains **Kathleen Moreo**, RN, BSN, BPSHA, CDMS, ABDA, owner of PRIME, a case management consulting and education company in Miramar, FL. "Our professional future may be in jeopardy because we haven't explained to consumers who we are and how we can help them receive appropriate health care. If we don't step up to the plate and define ourselves, others will step in and do it for us."

> **"Our professional future may be in jeopardy because we haven't explained to consumers who we are and how we can help them."**

"I recently saw a full-page ad in a physician management magazine for occupational therapists. In very few words, it explained how occupational therapists enhance the physician's job and improve patient outcomes," comments Moreo, who is president-elect of the Case Management Society of America (CMSA) in Little Rock, AR. "It was touching and effective. It explained that occupational therapy makes a difference in patient's lives. Why aren't we as case managers out there publicizing the impact we have on patients' lives?"

"Good public relations can create a demand for case management that will advance this profession and provide greater opportunities for case managers," says **Nancy Skinner**, RN, CCM, with IVonyx in Chattanooga, TN, and president of CMSA. "I want to see the day when patients diagnosed with a serious medical condition demand a case manager to help guide them through the health care system."

Define job, message

However, before case managers can bring their message to consumers, they must agree on a shared definition of case management and a common message. "We are entering the new millennium still plagued with internal conflicts in terminology when it comes to defining case management," says Moreo." If we don't come forward with one voice and one definition of case management, our message will be ineffective."

"Case managers must agree on one very brief, very caring sentence that explains what they do. Then they need to follow that message with personal case management success stories that support that definition," says **Brenna Harrington**, a health care public relations consultant based in Lawrenceville, GA, with 15 years of experience. She suggests case managers coin a phrase that explains their role in the health care delivery system and use it repeatedly when speaking to consumers or media about case management**. (For advice on how to talk to the press, see p. 19.)**

Some phrases she suggests might be effective include these:

- "Case managers try to take better care of patients by . . . ."
- "Case managers make every effort to help patients lead fuller lives by . . . ."
- "Case managers help patients receive access to appropriate health care by . . . ."

Once you clarify your message, you must select and study your audience before launching a public relations effort. "I realized that I needed to reach potential clients with my message," notes **Catherine Mullahy**, RN, BS, CRRN, CCM, president of Options Unlimited, a case management company in Huntington, NY, and author of *The Case Manager's Handbook*. "I asked my existing clients what publications they read and began to subscribe to those publications. I needed to understand what the perception of case management was, what those potential clients were interested in, and what problems they were trying to solve."

Mullahy hired a public relations firm to help her make contacts with the editors of business and health insurance journals. "I started writing articles for compensation management journals and other business publications. Once they were published, I asked for reprints and sent those to potential clients. It gave me more credibility."

Case managers also can "create" news of interest to publications that reach their patients or clients by suggesting a case management angle to topical issues, notes **Deborah Jensen**, president of An In-House Associate, a public relations and publicity firm in Huntington, NY. She offers these examples:

- legislation that affects patient care;
- a new drug for a chronic illness;
- a new or unique treatment or surgery;
- health care industry trends.

Speak to reporters

Jensen says case managers first should determine the appropriate editor, producer, or reporter, and then call or write with a story idea. For example, if it's a seasonal story on helping children manage their asthma, approach the parenting editor at a women's magazine or the health editor of your local newspaper. If it's a story about Alzheimer's disease, contact the health editor at magazines targeted to caregivers or the senior market.

"You might say, 'There's an exciting new treatment for Alzheimer's. I'm a case manager. I work with patients and their families to help them manage their medical conditions. Let me tell you the wonderful effect this treatment had on one of my patients,'" says Jensen. "Use a case of yours

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that came out exceptionally well to illustrate your point and make it come alive." However, she cautions that case managers should never identify a patient by name without first receiving written permission.

Don't be discouraged if an editor or reporter rejects your story suggestion. "By establishing contact, you've created an opportunity," she says. That journalist may call you a month later and say, 'I didn't use that idea, but I am planning an article next month on workers' compensation, are you interested in commenting on that?'"

It's also important to respond to articles that misrepresent case management, she suggests. "You can write a letter to the editor and then go one step further by suggesting a story idea on a related topic."

Letters to the editor work

Moreo recently wrote a letter to the editor after reading an article in *The Wall Street Journal.* "The article presented case managers as purse-string holders. I responded with a letter to the editor explaining CMSA's definition of case management. The letter ran. I believe it helped promote CMSA's philosophy of case management to anyone who read it."

The letter also created another educational opportunity, Moreo explains. "As a result of that letter, I received a very strongly worded letter from the vice president of a large workers' comp insurer. He had misunderstood some of my comments and taken great exception to them. I called him and explained the role of case managers to him on a more personal level. We had a great conversation. He even sent me a letter apologizing for his first letter. That letter in *The Wall Street Journal* created an educational opportunity."

Case managers can also take advantage of local health fairs and other community events to create consumer awareness about case management. "Sponsor a table at your community health fair. Hand out health education brochures. Talk to the people who come to your table. Tell them what you do," suggests Jensen. "It's up to every case manager and every case management department to establish a presence in the community. It's the ammunition you bring when you approach your higher-ups. It gives you the ability to say, 'See how integral we are to our organization? We help you gain new members and build loyalty in existing members.'" ■

Put your best foot forward

Experts offer tips for handling the press

Case managers are being caught in the backlash of anti-managed-care sentiment sweeping the country. Reporters on a deadline often don't have time to sort out the intricacies of the health care delivery system and see where case management fits. Although you can't prevent negative or misleading stories about case management from reaching your patients, you can follow some simple steps to ensure you communicate clearly if members of the media contact you for comment. **(For information on how to create a positive public image for your case management organization, see p. 17.)**

Here are a few pointers on handling the media from public relations and case management professionals:

❑ **Appoint a spokesperson.**

"First and foremost, appoint one or two spokespersons for your organization and always refer any calls from the media to your spokespersons," says **Deborah Jensen**, president of An In-House Associate, a public relations and publicity firm with case management clients based in Huntington, NY.

"Any information about your organization should always be filtered through these individuals. This ensures you deliver a consistent message. It also enables the media to know who to come to for information," she explains. "It sets up a good relationship with the media and makes it more likely that your message will be reported accurately."

"Remember, your best spokesperson may not be your organization president or director of case management," adds **Brenna Harrington**, a health care public relations consultant in Lawrenceville, GA, with 15 years of experience. "It may be that second year case manager who is very enthusiastic and communicates well. However, make sure you choose the spokesperson who is knowledgeable as well as enthusiastic."

❑ **Create a tip sheet.**

Keep a little tip sheet in your mind, or even written out, that reminds you how you want to position your company or define case management, suggests Jensen. "Take a beat and think about your response. Sometimes, teaching opportunities come quickly and unexpectedly. You have to be prepared."

❑ **Understand the facts.**

If you are contacted by a reporter for comment on legislation or a legal case against a managed care organization or hospital, make sure you are fully informed about the issue before commenting, adds Jensen. "If you are unfamiliar with the issue or the case, politely request that an article or other background materials be sent or faxed to you before you comment," she suggests.

❑ **Use simple language.**

When talking with the media, avoid medical or technical terms, says Harrington. "Use simple English. Focus on how case management helps patients get well faster, cope with a loss, or receive access to appropriate care. Try to explain what you do in 100 words or less. The biggest mistake you can make with the media is failing to make your message personal and simple." She suggests case managers use real-life examples to communicate their message. "Journalists today want to put a face on the news. Poignant anecdotes get the attention of the media and consumers."

Jensen agrees. "Examples work. Whenever you are asked to comment on a situation, explain how you have handled similar situations in the past." She suggests using phrases such as these:

— "I have always found that . . . ."

— "The way my organization normally handles that type of situation is . . . ."

"Whatever phrase you use, make sure you position the case manager as the concerned patient advocate," she adds. "For example, if you are asked to comment on a lawsuit involving an injured child, express concern for the family. Avoid going into clinical details of the case. Don't elaborate on the medical decisions that were made and whether or not you agree with them."

❑ **Find out the reporter's deadline.**

You don't have to respond immediately to a request for a comment, say Jensen and Harrington. "Always hesitate prior to answering. You don't have to answer shotgun fashion. It's OK to ask for the reporter's deadline and ask whether you can call the reporter back in an hour," Jensen says. "This leaves the reporter with the feeling that you are being cooperative and still allows you time to think about what you need to communicate."

However, case managers should avoid phrases such as "no comment" and "I can't comment on that," cautions Harrington. Instead, she suggests case managers use these kinds of phrases:

— "I know that's an important question, but I don't know enough to give you the answer you need right now."

— "I need to look into this more thoroughly and get back to you. When is your deadline for this story?"

If you receive a phone message from a journalist, return it, she advises. "Case managers must understand that reporters often have 24 hours or less to put together a story. This may be your only shot. You can put the reporter off, but you may never get your message heard."

❑ **Offer to review the material.**

"Some reporters tell you straight out they don't allow sources to review information before it's published," says **Catherine Mullahy**, RN, BS, CRRN, CCM, president of Options Unlimited, a case management company in Huntington, NY. "Others allow, or even welcome, you to review the article to make sure they got the facts right." ■

New certification targets hospital CMs

The American Institute of Outcomes Case Management (AIOCM) in Whittier, CA, offers a case management accreditation program targeted to hospital-based case managers. AIOCM began certifying case managers early last year and has certified just over 200 case managers.

The exam is open to case managers from a variety of health care professions, including nurses, social workers, respiratory therapists, and pharmacists. It's offered several times each year nationwide through seminars sponsored by Health Care Resource Group, also of Whittier, CA.

Eligibility is based on a scoring system that awards case managers points for professional experience, professional activities performed as part of the case manager's job responsibilities, and education. The cost of the application is $50. The examination fee is $75. Annual membership in AIOCM also is $75. In addition, once certified, case managers must be recertified every two years at a cost of $50. Applicants who pass the AIOCM certification examination may use the letters "CMC" for "case manager certified" after their names in professional correspondence and on business cards.

AIOCM is not associated with the National Academy of Certified Care Managers (NACCM) in Colchester, CT, which developed and oversees the care manager certified examination; NAACM's certified professionals also use the abbreviation

"CMC." NACCM began certifying care managers in early 1996 and since has certified more than 300 care managers. **(For further background on the NACCM exam, see *Case Management Advisor,* January 1995, pp. 12-13, and January 1997, pp. 1-6.)**

[Editor's note: For more on the AIOCM examination, contact: AIOCM, 12519 Lambert Road, Whittier, CA 90606. Telephone: (562) 945-9990. Fax: (562) 698-2339. For more on the NACCM examination, contact: NACCM, P.O. Box 669, 244 Upton Roaf, Colchester, CT 06415-0669. Telephone: (800) 962-2260 or (860) 537-6865.] ■

Geriatrics/long-term care

Study finds many seniors are abused

Here's how you can identify and handle abuse

As many as 2 million elderly people are abused each year, and case managers are in an excellent position to identify and help them. Recent research, The National Elder Abuse Incidence Study, concludes that only 16% of abuse cases involving people over age 60 are reported to local Adult Protective Services (APS) agencies. The exact number of abused seniors is difficult to determine because health care professionals and others often miss the signs of abuse.

The study, which ran from October 1994 to December 1997, was conducted by the National Center on Elder Abuse at the American Public Human Services Association in Washington, DC, and Baltimore-based Westat, a social science and survey research firm.[1] The study showed that the greatest percentage of cases of elder abuse occurred among people age 80 or older. More than half of the cases of neglect involved people in the 80-plus age group, and about 44% of physical abuse involved people in that age group.

Every state has laws on elder abuse. In fact, most require health care professionals to report suspected or known abuse. "Every time we hire a new case manager, we include information on abuse, neglect, and exploitation in the orientation packet," says **Betsy Pegelow**, RN, MSN, director of special projects and the Channeling program at Miami Jewish Home and Hospital for the Aged. "In Florida, any professional who observes abuse must report it. The orientation packet includes the state's definitions of abuse, neglect, and exploitation. Case managers are on the front lines. They observe the patient and the caregiver interactions."

Channeling, a caregiver support program, trains case managers on the programs, policies, and procedures for reporting suspected elder abuse. "We tell case managers to discuss their concerns with their immediate supervisor and then bring the case to the attention of the clinical supervisor," Pegelow explains. "If we are not sure whether abuse is taking place, we may call in the home health agency to be our additional eyes and ears. The home care aide may observe behaviors that the case manager isn't aware of."

Connecticut Community Care (CCCI) in Bristol, TN, also provides a thorough orientation on elder abuse for new case managers. "We go over signs and symptoms of abuse. Most of our case managers come from a home health background and are already somewhat familiar with issues of abuse," says **Sherry Ostrout**, MSW, social service regional supervisor for CCCI.

Make yourself the 'good guy'

Of course, it isn't always easy for a case manager to continue working with a client after reporting suspected abuse to APS. "In Florida, when Adult Protective Services goes out, they don't tell the abuser who made the report. Many times the family suspects it is the case manager. It's one of those situations you have to be prepared to handle," says Pegelow. "It helps for case managers to focus on their client. Your ultimate goal is to protect the client."

CCCI case managers work in teams. "If it became very difficult for a case manager to continue working a case, it might be better for the client to have another case manager on the same team take over," Ostrout suggests. "Fortunately, we've developed an excellent relationship with Adult Protective Services. Often , they take the role of the 'bad guys' and let us be the 'good guys' who are there to help the client and the abuser through the situation."

The five types of abuse involving the elderly typically are described as neglect, emotional, physical, financial, and abandonment. The National Elder Abuse Incidence Study found that the greatest percentage of elderly who suffered from any one of those five types of abuse had

household incomes of less than $10,000. Also, while more elderly women than men are victims, there is a higher percentage of men who are abandoned. About 62% of the victims of abandonment were men, according to the national study, compared with about 38% women. On the other hand, women (76%) were more likely to be victims of emotional abuse than were men (24%).

Elder abuse doesn't follow the same pattern as domestic violence. Whereas domestic violence cases of adults under age 60 typically involve a male abuser and a female victim, elder abuse perpetrators may as likely be women. The study showed that 52.5% of the incidents involved male abusers, and 47.5% involved female abusers. If the abuse is neglect, which is the most frequent type of maltreatment committed, it's more likely to involve a female abuser. The other forms of abuse are more likely to be caused by men.

Training helps fight abuse

The National Elder Abuse Incidence Study recommends that health care professionals be trained to detect instances of abuse and neglect. Elderly abuse victims often are more isolated than other abuse victims, so case managers may be their first line of defense.

"One area of elder abuse which is grossly underreported and poorly understood is spousal abuse in the elderly," says Ostrout. "Oftentimes, it's incorrectly labeled under caregiver stress or general elder abuse."

Ostrout recently developed a case manager training program on spousal abuse in the elderly. She since has presented the same training program to local agencies on aging and protective services employees. "How you intervene in cases of spousal abuse in the elderly depends greatly on whether the abuse is part of a long-term pattern of abuse or a new behavior. The first step in these cases is to determine whether the abuse is short-term or long-term," she explains.

If the behavior is short-term, case managers must determine what is causing it, she says. "These reasons can range from serious changes in the victim to cognitive changes." She suggests case managers ask the following questions:

- Has the victim developed an increased physical dependency on the abuser?
- Has a new onset of health problems occurred in the victim or abuser?
- Have there been cognitive changes in the victim or abuser?
- Is the abuser under increased stress?

"If this is short-term or recent-onset abuse, there is a reason. Something has caused the abuse," Ostrout says. "The case manager may observe or suspect that medications are being withheld or the patient is being neglected."

Case managers should request a full physical work-up of both the victim and the abuser, she says. "Once the cause of the abuse is identified, an appropriate management strategy can be planned. If the problem is caregiver stress, the solution may be as simple as working on relieving that stress through respite care."

Long-term spousal abuse is much harder for case managers to address. "Your client may have been in an abusive relationship for 50 years," she says. "In this case, the best person to help you understand how to manage the situation is the victim. What we may view as denial on the victim's part may be a coping mechanism that has worked effectively for 50 years."

Signs of long-term spousal abuse case managers may observe in victims include low self-esteem, anxiety disorders, depression, delusional behavior, preoccupation with abusers' comforts and needs, and denial of violence.

"Case managers must realize that if a client says they are being abused, they are probably minimizing the actual level of abuse," Ostrout says. "This is a difficult situation for case managers to remedy. Unlike short-term abuse, there may not be a true solution. The best thing we may be able to do is to tell the victim in advance that a report is being filed so that the victim can take steps to protect their own safety. Listen to the victim. The victim is the expert on how to handle the abuser."

Case managers also can help victims of abuse rebuild their self-esteem. "Case managers can help victims separate themselves from the abuser by developing the victim's sense of self." **(For other suggestions and a list of resources, see stories on pp. 23-24.)**

Pegelow adds one note of caution: "Sometimes adults with dementia report they are being abused by their caregiver when it's not really true. Of more concern is a client who denies abuse due to fear of nursing home placement."

Reference

1. National Center on Elder Abuse of the American Public Human Services Association, Westat. The National Elder Abuse Incidence Study. Washington, DC; 1998. ■

Create a patient brochure on domestic violence

As a case manager, you occasionally may observe cases of elder abuse or domestic violence, and you're required to report any suspicions of abuse to supervisors. You may ask a home health agency to send a social worker to the home for further assessment of the situation and report the suspicions to state and local officials. But what happens next?

It's probably a good idea to have a simple educational brochure available for clients who are victims of abuse. This resource should offer tips on how clients can protect themselves from potentially dangerous or financially exploitative situations.

Go to the sources

These resources might help you create an elder abuse brochure:

• Karen Greene Blondell, Kentucky Commonwealth attorney with the 44th Judicial Circuit in Middlesboro, KY, has created a "Domestic Violence Personal Safety Plan." Telephone: (606) 248-0224.

• Crime Prevention Center, Office of the Attorney General, P.O. Box 944255, Sacramento, CA 94244-2550.

• Domestic Violence Project, 6308 8th Ave., Kenosha, WI 53143. Telephone: (414) 656-8502. Fax: (414) 656-0075.

The following guidelines are based on educational materials found in the resources listed above:

1. Protect yourself from an explosive incident.

• Pay close attention to your intuition about whether someone means to harm you.

• Let a health care worker or someone else know if someone in your household is using drugs.

• Watch for signs that someone in your household hears voices, imagines evil conspiracies, or talks about murder and violent acts.

• If an argument seems unavoidable, try to have it in a room or area where you have access to an exit. Try to stay away from the bathroom, kitchen, bedroom, or anywhere else weapons might be available.

• Identify one or more neighbors you can tell

On-line Elder Abuse Resources

Web sites help fight abuse

There is plenty of useful material about elder abuse available on-line. You can find out everything from the racial background of elder abuse victims to the name, address, and phone number of the organization that fights domestic violence in your state. Web sites you may find useful include:

• **www.aoa.dhhs.gov/abuse/report/default.htm:** This site contains a 28-page report that details results from the National Elder Abuse Incidence Study.

The study was conducted by the National Center on Elder Abuse at the American Public Human Services Association in Washington, DC, and Westat of Baltimore. The study's conclusions are included in the executive summary on the first page.

• **www.ncadv.org:** The National Coalition Against Domestic Violence in Denver sponsors this site, which is easy to read and use. It includes phone numbers of more than 50 state domestic violence organizations and lists national and international organizations and resources.

There's also a section that could be used as a patient teaching guide that tells abused people how to get help and how to plan for their safety. It also includes links to other resources.

• **www.ink.org/public/keln/keln_abuse.html:** This site has some good information that explains whether elder abuse is a crime and offers crime prevention tips for seniors. It also has a variety of links to other elder abuse sites.

• **www.cyberbeach.e/~seac/eldabuse.htm:** This site includes clear one- or two-page printouts you can download. It includes a page with case studies of elder abuse, a page that lists causes of elder abuse, and a page giving action plans for preventing elder abuse.

• **www.mincava.umn.edu/:** Sponsored by the Minnesota Center Against Violence and Abuse, this site has a variety of information, including papers and reports on abuse and a complete file called "Domestic Violence Legislation Affecting Police and Prosecutor Responsibilities: A 50 State Review" from the Institute for Law and Justice. It is available to read on-line or to download.

More Abuse Resources

• **American Academy of Nursing:** report on violence and health care, *Violence: A Plague In Our Land* ($19). Call (800) 637-0323. 600 Maryland Ave. S.W., Suite 100 W, Washington, DC 20024-2571. Phone: (202) 651-7238. Fax: (202) 554-2641.

• **American Association of Medical Assistants:** article on elder abuse in *Professional Medical Assistant* ($3). Call (800) 228-2262. Communications, 20 N. Wacker Drive, #1575, Chicago, IL 60606-2903. Phone: (312) 899-1500. Fax: (312) 899-1259.

• **American Psychological Association:** *Violence in the Family*, a report of its Presidential Task Force on Violence and the Family (first copy free; extra copies are $5 each). 750 First St. N.E., Washington, DC 20002. Phone: (202) 336-6046. Fax: (202) 336-6040.

• **Chicago Abused Women's Coalition Hospital Crisis Intervention Project:** articles and free screening tool. P.O. Box 477916, Chicago, IL 60647-7916. Phone: (312) 433-2390. Fax: (312) 433-2391.

• **Domestic Violence Project**: free protocol, *The Assessment & Treatment of Victims of Domestic Abuse*, with forms for medical documentation. 6308 8th Ave., Kenosha, WI 53143. Phone: (414) 656-8502. Fax: (414) 656-0075.

• **Domestic Violence Training Project**, **University of Connecticut:** *A Guide for Health Care Professionals* (free). Kate Paranteau, 900 State St., New Haven, CT 06511. Phone: (203) 865-3699. Fax: (203) 865-3779.

• **Family Violence Prevention Fund, Health Resource Center on Domestic Violence:** protocols, packets, posters, bumper stickers ($0-$1 + $5 shipping), *Best Practices: Innovative Domestic Violence Programs in Health Care Settings* ($5), and *Improving the Health Care Response to Domestic Violence: A Guide for Health Care Providers* ($75). 383 Rhode Island St., Suite 304, San Francisco, CA 94103. Phone: (888) Rx-ABUSE. Fax: (415) 252-8991. E-mail: fund@igc.apc.org. Web: www.fvpf.org/fund/.

• **National Coalition Against Domestic Violence:** *National Directory of Domestic Violence Programs: A Guide to Community Shelter, Safe Home and Service Programs* ($50 + $7 shipping). P.O. Box 18749, Denver, CO 80218. Phone: (303) 839-1852. Fax: (303) 831-9251. Web: www.ncadv.org.

• **New York State Department of Health and Office for the Prevention of Domestic Violence:** information packets, *Domestic Violence Intervention Guide for Health Care Professionals,* a victims' rights notice, a personalized safety plan, and other materials (first copy free; extra copies $5 each). Domestic Violence Program Specialist, Capitol View Office Park, 52 Washington St., 3rd floor, Rensselaer, NY 12144. Phone: (518) 486-6262. Fax: (518) 486-7675.

about the violence and ask them to call the police if they hear a disturbance coming from your home.

• Call a shelter hotline if you need to leave the house immediately.

• If someone has harmed you physically, tell your health care provider or the police department about the assault. They can locate help for you.

2. Secure your home.

• If someone you know is becoming violent, and this person does not live with you but has a key to your home, then have your locks changed and secure your windows.

• Discuss a safety plan with a relative or friend you trust.

• Inform your neighbors or a landlord that a person who had been living with you no longer does so and should not be allowed in the building.

• Arrange to have your telephone hooked up to a caller ID service or an answering machine so you or a trusted relative can screen your calls.

• Install deadbolt locks on all your doors.

• Install a peephole in your front door so you can see visitors without opening the door.

3. Protect your finances.

• Don't keep more cash than necessary in your purse or wallet.

• Don't give out your credit card or checking account numbers to anyone over the telephone, unless you have called a mail order business or similar company to make a purchase.

• Never withdraw money from your bank account for anyone except yourself.

• Have your government checks or paychecks deposited directly to your bank account.

• Check your credit card bills each month to make sure that you made all of the charges listed.

• Cut up all department store and other charge cards that you no longer use.

• Put a 900-number block on your telephone so no one will be able to run up hundreds of dollars in calls to psychic hotlines and other types of services for which the caller must pay by the minute.

• If you've been swindled or conned, report the crime to your local police or the district attorney's office. ■

CMs open doors for psych patients

How to educate employers about accommodation

Most problems case managers face when handling disability claims for psychiatric disorders emerge from communication gaps between employers and staff and a general lack of understanding about psychiatric disability. In most cases, the case manager is the person best-suited to be an objective third party who heals the employer / employee relationship and facilitates the accommodations that keep the employee on the job.

"In many cases that involve mental illness, the relationship between the employer or supervisor and the employee creates internal stress for the employee and exacerbates the situation," says **Mark Raderstorf**, CCM, CRC, a licensed psychologist and president of Behavioral Management in Minneapolis. "Stress in the work environment often tips the scale that sends the employee over the edge. The case manager can be instrumental in rebuilding relationships and fashioning return-to-work plans that keep the employee on the job."

Mediation helps at work

However, managing psychiatric disabilities takes special skills that may not come naturally to many case managers. "You must be a person that is comfortable going into the work environment and addressing touchy issues in an objective way," he says. " Many of the same skills that apply to traditional medical case management apply here as well, but in addition you must be able to mediate workplace conflict."

Raderstorf recalls a head injury client with major depression. "Both sides were very distrustful of each other. The patient had memory problems and difficulty managing multiple tasks, but the real issue was long standing bad blood between the employee and his supervisor and coworkers." With his client's permission, he set up a meeting for the client, his wife, the company personnel director, and the client's supervisor. "We called it a return-to-work planning session. It was really a mediation. Unless both sides, employee and employer, trust each other, any plan the case manager develops for return-to-work falls apart."

Employers often have little knowledge or experience with mental illness, he adds. "Supervisors and co-workers both have misconceptions about the employee with a psychiatric disability. The disability manifests itself in the workplace in ways that impact co-workers." Workplace behaviors common in employees with psychiatric disabilities include reduced productivity, absenteeism, and lethargy.

"Other employees have to pick up the slack, and they begin to resent the employee with the psychiatric disability. If a co-worker has cancer and is tired due to chemotherapy, co-workers feel a great deal of empathy and willingly help the employee," Raderstorf says. "However, employees with psychiatric disabilities are often seen as lazy people who just want a free ride."

Case managers may have to educate co-workers before an employee with a psychiatric disability can successfully return to work. Brown-bag lunch-and-learn sessions work very well, he says, enabling case managers to provide general information about a psychiatric disability such as

What is a psychiatric disability?

The following disorders are recognized by the Equal Employment Opportunity Commission in Washington, DC, as psychiatric disabilities that qualify for workplace accommodation under the Americans with Disabilities Act (ADA):

- bipolar disorder;
- major depression;
- post-traumatic stress disorder;
- anxiety disorders.

These psychiatric conditions are not considered disabilities that qualify for workplace accommodation under the ADA:

- sexual behavior disorders;
- compulsive gambling;
- kleptomania;
- pyromania;
- substance abuse.

In addition, bad character traits and poor work behavior are not considered disabilities that qualify for workplace accommodation. Those include:

- irritability;
- chronic lateness;
- poor judgment.

depression. "The sessions usually evolve into a vehicle for co-workers to vent their resentments about the disabled employee. The sessions also help co-workers understand that the employee has a medical condition that was fueling the performance problems and help them look at the person in a more supportive light."

The one mistake employers always should try to avoid is spending too many resources simply trying to prove a psychiatric disability exists, says **Carol Miaskoff**, BA, JD, assistant legal counsel for coordination in the Office of Legal Counsel for the Equal Employment Opportunity Commission in Washington, DC. "Establishing psychiatric disability may be necessary to some degree, but it is also often counterproductive," she says. "There are legal consequences for employers who go through a long back-and-forth process to establish a psychiatric disability without focusing on effective accommodation under the Americans with Disability Act [ADA] to get their employees back into the workplace."

Getting back to work, properly

Miaskoff says case managers should advise employers to follow a more moderate approach that moves employees with psychiatric disorders back to work more quickly. She suggests the following steps:

- Ask the employee's health care provider to confirm the employee is under treatment for a psychiatric disorder covered under ADA**. (See box on p. 29 for psychiatric conditions that merit accommodation under ADA.)**
- Ask the health care provider to provide a summary of the employee's condition and an evaluation of its seriousness.
- Talk to the employee and receive consent to discuss the employee's mental health status and possible accommodations with the employer.
- Request a good job description from the employer and begin to discuss possible work adjustments.

It's important that in trying to accommodate the employee's disability, supervisors don't change the standards of the job, Raderstorf says. "The approach has to be, 'These are the standards of the job. How can we help the employee meet them?' If employees are allowed to meet lower productivity quotas, the case manager should make sure that it's only for a temporary period."

Raderstorf and Miaskoff say reasonable accommodations for psychiatric disabilities include paid or unpaid time off, part-time work to start, or a later start time. An employee may have a medication that takes time to adequately control symptoms first thing in the morning. In those cases, a later start time may be the only necessary accommodation, Miaskoff observes. Here are five other accommodations to consider:

1. Flexible hours to accommodate treatment.

An employee may need an expanded lunch hour once a week for therapy or medical appointments. "An employee with major depression may ask to work at home one day a week to help cut their stress levels. That is also a fairly easy and reasonable accommodation for an employer to make," says Miaskoff.

2. Physical changes to the environment.

Physical accommodations might include room dividers, partitions, or soundproofing. "We had a case where an employer ran a small printing plant. The noise in the plant exacerbated the employee's mental disability. The employer argued that keeping the plant quiet for the benefit of one employee with a mental disability would create an undue hardship, and we agreed," says Miaskoff.

"In that case, perhaps the employee could wear ear plugs. The key is to remain flexible and seek creative solutions which don't place an undue burden on the employer," she says.

In another case, the employee worked in a large room with many people answering telephones. "The ringing of the phones distracted the employee with the psychiatric disability," she says. The employer turned down the volume and pitch of the telephone ring. You just have to give someone a fighting change. You don't have change the entire workplace to comply with ADA."

Remember, many individuals with psychiatric disorders are easily distracted. "Case managers should assess the workplace," she says. "Is the client's desk directly across from the water cooler? Is the client's work station next to the fax machine? For a person with acute concentration difficulties, external distractions are very difficult to handle."

3. More regular supervision and feedback.

"This may help an employee who has difficulty structuring their workload and staying on track," she notes. "Case managers can educate supervisors about special needs, such as giving

employees only one deadline at a time." Employees with concentration problems may need to be given assignments on a daily basis, Raderstorf adds. "I also suggest that supervisors provide written as well as verbal instructions for these clients."

4. Job coach for technical assistance.

Job coaches actually go to work with the employee to observe and smooth the way. "I had a client with anxiety and paranoia who needed a great deal of handholding to help her through daily stresses when she first returned to work," Raderstorf says.

"She was convinced her co-workers were 'out to get her.' She needed a sounding board to give her a more balanced perspective of what was happening in the workplace."

Another client with major depression was receiving electroconvulsive therapy, which created short-term memory loss, he notes. The client was a computer analyst whose work was very technical. Raderstorf arranged for the employer to hire a computer consultant to meet with his client an hour a week for about three months to review the client's work.

"The consultant was someone on the sidelines to coach him along. It not only reassured the client that he could still do his job, but where the client did make mistakes the consultant helped him correct them. The supervisor simply didn't have the time for that type of micromanagement and remedial training," he says.

5. Rehabilitation case manager.

Sometimes, hiring a case manager is considered an accommodation, says Raderstorf.

"One thing I'd love case managers help more employers to understand is that an employee with a psychiatric disability isn't going to come in and ask for help under ADA," Miaskoff says. "The employer has to listen to what the employee is saying. If they hear a request for help, they can't ignore it. They have to respond. If employers wait until an employee makes a formal request for accommodation, it's often too late to avoid legal trouble."

The EEOC publishes its policy documents or "guidances" for ADA accommodation on its Web site at www.eoc.gov, Miaskoff says. She encourages case managers to download the information and use it to help navigate the tricky waters of ADA accommodation for psychiatric disabilities. ■

■ Tips from the Field ■

Select contractor with accessibility experience

Not all contractors understand the special needs of the elderly or disabled. When it comes to helping a client select a contractor to make accessibility modifications, it pays to go with experience, says **Bill Paglia Scheff**, vice president of construction services for the nonprofit Corporation for Independent Living in Wethersfield, CT, and general contractor for its Home for Living service.

Here are his tips for selecting a contractor who can assess your client's needs:

❑ **Choose experience over cost.**

"Initially, people are concerned with price," says Paglia Scheff. "When evaluating competing quotes for a job, homeowners should keep in mind that they are paying for expertise, not just construction."

He works with clients to gain a complete understanding of their needs. "I had one man who asked me for a quote on widening the door to his bathroom so that he could get into the shower area with his wheelchair," he recalls.

"The contractor has to spend time with the client, watching activities of daily living before making decisions about the best modification."

"Before I gave him an estimate on widening the door, I took the door off the hinges to see if that would enable the man to pass through the entryway. Then I assisted him shifting from his wheelchair to his shower chair. His wife told me no one had ever taken her husband through that routine before to see if he could actually complete the transfer.

"I have no problem asking a client to sit on the toilet, if that's an issue they have trouble with. The contractor has to spend time with the client watching activities of daily living before making decisions about the best modification to improve the client's quality of life. Sometimes the solutions become very detailed like lowering a bar by two inches."

❑ **Look for more than one answer.**

"Choose the contractor who proposes options that other contractors may not be aware of," he says. "Make sure the contractor also offers more than one possible solution to your specific needs."

• **Ask for references.**

Make sure the contractor you choose is legitimate, he suggests. "Find out how long the company has been in business and has successfully dealt with accessibility issues. Ask for names and phone numbers of previous customers, and take the time to call them," he adds.

Clients should ask contractors for pictures of their past projects or, if possible, they should visit the homes in person. "Visiting a modified home is the best way to visualize and approximate the work that's going to be done." In addition, many accessibility contractors now list themselves by specialty in their local yellow pages, he says, adding that the National Association of Home Builders in Washington, DC, is also a good resource for finding reputable local builders with accessibility experience, he says. To contact the association, call (202) 822-0200.

"Choose the contractor that pays attention to blending the ramp into the landscape, rather than just slapping one onto the front of a house."

• **Expect customer service.**

Ask all contractors who bid on the job what type of warranty they offer. "A quality contractor will stand behind the work. Homes for Living offers a five-year warranty on all work."

• **Consider the aesthetics of the design.**

"Modifications for accessibility don't have to look institutional or create an eyesore," he says. "People have the impression that modifications, such as entrance ramps, must become a monstrosity that doesn't fit in. Choose the contractor that pays attention to blending the ramp into the landscape, rather than just slapping one onto the front of a house."

• **Determine if time is a factor.**

"In some cases, a client can't come back into the home until the modifications are complete, so a contractor's ability to get an experienced crew on the construction site quickly is critical from the homeowner's perspective." ■

Disease management/managed care

Study proves system heals wounds faster

Patients also required fewer nursing visits

Wound care can be a financial risk for home care agencies and health plans because of the poor clinical results that often persist even after months of nursing care. A recent pilot study of home health patients found that combining products that provide a better healing environment and a more structured wound care protocol reduces the time to wound closure by 52% and the total number of nursing visits by 63%. The total cost savings is more than $3,000 per patient.

Bayada Nurses Home Health Specialists of New Jersey in Morristown and Horizon Blue Cross/Blue Shield of New Jersey in Newark coordinated efforts to evaluate wound care outcomes in the home setting using both a traditional wound care treatment and the standardized Optimum Outcomes Wound Management System developed by Derma Sciences of Princeton, NJ.

"We were experiencing some stubborn wounds that weren't healing. It seemed reasonable to do a small pilot study to try the Derma Sciences system," says **David Bendich**, MD, senior medical director for quality management for Horizon Blue Cross/Blue Shield. "The biggest problem was convincing doctors to try the system. Many were resistant at first. We went to the doctors to educate them. Finally, several agreed to try the system for patients whose wounds wouldn't heal."

"The outcomes we achieved are important to us because of our need to work with managed care organizations," adds **Donna J. Angelini**, RN, clinical coordinator for Bayada. "Plus the program is of great value because of the changes in Medicare reimbursement. We are able to achieve superior outcomes in less time, which makes this very attractive in a capitated environment." **(See box, p. 33, for outcomes data.)**

The study included 20 patients with 25 wound sites. Those sites included stage 2, 3, and 4 decubitus ulcers, dehiscence, stasis ulcers, ischemic ulcers

and surgical wound sites. The physician and the home health nurse determined whether wounds were healing using a 14-point assessment tool. Patients initially were treated with the traditional treatment regimen. If the wound did not heal, the wound treatment was changed from the current treatment to the Derma Sciences system.

The Optimum Outcomes Wound Management System uses proprietary wound healing products containing zinc, vitamin B_6, magnesium, vitamin A, and other elements that are carefully pH balanced.

System includes care plans, consultants

The wound management system also includes the following items:

- care plans and protocols for wound management, which are wound specific;
- wound care education for nursing staff;
- wound care consultants for nursing staff support;
- data collection mechanism.

"The data collection tool collects clinical and economic information so the customer has a basis for comparison between their traditional wound care and our system," notes **Richard Mink**, BS, MBA, vice president and chief operating officer of Derma Sciences. "The management system itself costs nothing," he adds. "Customers agree to buy our products, and we provide the training, the protocols, and the data collection mechanism."

"The products aren't that much more expensive than other wound care products," says Bendich. "The small increase in product cost is more than justified. We brought wounds to closure that we didn't expect to heal, and it took less time."

The Derma Sciences protocol requires much closer monitoring of wounds than many home health agencies traditionally provide, Angelini says. "But Derma Sciences was very supportive. They came into the agency and trained staff at all 26 service offices. They also provided good support services."

To ensure that wound care was consistent for the purposes of the comparison study, the same primary nurse visited patients in the study each Monday to provide care and monitor progress. "I think it makes a difference that each nurse followed the same wound protocol," she says. "We had everyone providing care the same way. In hospitals and home care, unless a very specific protocol is developed and followed, each nurse does things slightly differently, and that can affect outcomes." The Derma Sciences products are much easier for both nurses and patients to use properly, she adds. "The ease of use really adds to the attractiveness of the system. It's much easier to teach families and patient how to use the Derma Sciences products than it is to teach them how to do a sterile wet-to-dry saline package. It means that families are more eager to participate in wound care, and we can discharge patients from nursing service quicker."

"The pilot study worked so well that when doctors call in with wounds, we tell them about the system," says Bendich. "Some doctors are still reluctant to agree to try it, but Bayada is willing to go out and speak with doctors and often convinces them to try the system."

"We have to convince doctors that what they've been doing doesn't work. Many of the traditional dressings include chemicals that we think somehow actually kill growing tissue rather than promoting healing," he says. "These dressings do cost slightly more, but the difference in cost is minimal, and the outcomes speak for themselves." ■

Portrait of Success

Bayada Nurses Home Health Specialists of New Jersey in Morristown and Horizon Blue Cross/Blue Shield of New Jersey in Newark coordinated an effort to compare traditional wound care outcomes to outcomes achieved in the home setting using proprietary products developed by Derma Sciences of Princeton, NJ.

Here's a summary of what they found:

- Of 21 wounds treated with Derma Sciences products and protocols, 14 (66%) healed, compared to four of 25 (16%) wounds treated with the prior treatment.
- Wounds treated with Derma Sciences system healed in an average of 29 days, compared to an average of 61 days with the prior treatment.
- The average cost per healed wound was $1,825 for wounds treated with the Derma Sciences system, compared to $5,500 for wounds treated with the prior treatment, for a 67% total decrease in costs.
- The average number of nursing visits was 25 for the Derma Sciences system, compared to 68 for the prior treatment, for a 63% total decrease in nursing visits.

Nutrition protocols improve wound outcomes

Diet is the solution

Pressure ulcers are costly and preventable, as is unintentional weight loss in elderly patients. Some experts say a key component to preventing these problems is to focus on patients' nutrition and diet. **(See related story on wound care, p. 32.)**

The Chicago-based American Dietetic Association (ADA) has medical nutrition therapy protocols for the prevention of unintentional weight loss and treating pressure ulcers, developed by dietitians and published by the ADA and Mobile, AL-based Morrison Health Care.

"Every year, about 60,000 people die from complications related to pressure ulcers," says **Jody Vogelzang**, MS, RD, LD, FADA, president of JLV and Associates in Southlake, TX. Vogelzang chairs the dietetic practice group of the American Dietetic Association.

"Unintentional weight loss is an indicator of a lot of co-morbidities," Vogelzang says. "Malnourished older Americans can attract more infections and diseases, and surgery is riskier for them." Patients with either a pressure ulcer or unintentional weight loss can experience high medical costs and poor outcomes in disease treatment or surgery recovery.

Packet includes charts, Braden Scale

For each of the protocols, four interventions are spaced two to four weeks apart, Vogelzang says. The protocols also include flowcharts and a second page that has spaces for the clinician to check specific assessment items for each intervention date. The Braden Scale for predicting pressure sore risk also is included in the protocol packet.

The protocols were published by the American Dietetic Association in a manual, *Medical Nutrition Therapy Across the Continuum of Care*. The manual comes with a computer disk so health care providers can alter the protocols to better fit their own organizations. The manual and disk cost $90 for nonmembers or $75 for members. Shipping costs 10% of total. For more information about the pressure ulcer and unintentional weight loss nutrition protocols, contact the American Dietetic Association at (800) 877-1600, ext. 5000. ■

Program tries new recruiting approach

Will targeted messages attract participants?

As your disease management programs mature, measuring outcomes that demonstrate their success may not be enough to help you enroll more participants or attract new clients.

The Asthma Self Management Program (ASMP) has proven its worth. Twelve-month outcomes for the program developed by Glaxo Wellcome Care Management in Research Triangle Park, NC, showed a return of $1.85 for every dollar invested. That figure doesn't take into account indirect cost savings due to reduced absenteeism and increased productivity.

Program shows results

The program includes eight hourlong asthma education sessions. Not only did the 12-month outcome study prove that participants significantly reduced their use of the health care system for asthma-related problems, it also showed they improved their productivity and general well-being. **(For specific outcomes data, see box, p. 35. For a more detailed description of the ASMP program, see *Case Management Advisor*, January 1998, pp. 10-12.)**

"We know the program works. What we're changing now is the way we recruit and retain patients," says **Mark Santry**, director of the respiratory management group for Glaxo Wellcome Care Management.

"We commissioned research to help us understand what motivates people to participate in disease management programs and incorporated what we learned into our recruiting materials and methods," he explains.

The new materials are tailored to the program's target audience, he notes. "We've identified people as 'high utilizers' or 'light utilizers' based on their use of the health care system. The new recruiting messages are targeted to appeal to potential participants based on their use of the health care system."

Glaxo Wellcome also has changed the media it uses to reach potential ASMP participants. "We've moved away from print and video messages to a telephone outreach approach. We

use both live and passive outreach," he adds, explaining that "passive outreach" includes the announcement of a toll-free number participants can call for additional information about ASMP.

Most of the evidence that this new, more tailored approach is working has been anecdotal, he says. "We think the impact has been significant and will continue to show increases in participant recruitment and retention."

Tailored outcomes, too

Glaxo Wellcome also applies a tailored approach to the outcomes reports it prepares for its customers. "If I'm an employer, I want to hear about productivity and absenteeism, not just health care utilization. We've employed a number of instruments so that we can provide a wide range of outcome variables that apply to most of the customers we serve," Santry explains.

In addition to utilization data, Glaxo Wellcome measures SF-36 results for each participant and a functional status instrument that measures improvements in productivity. Outcomes for each participant are measured before their first ASMP class, after their last ASMP class, at three months after completing the class, at six months, and at 12 months.

Letting the customer decide

"We tailor our outcomes presentations based on our preliminary implementation meeting with the client. Maybe all they want to hear is how many hospital admissions there have been," Santry says. "If that's the case, that's what we report back. We let the customer dictate the level of detail based on internal needs, but the data is there if they want it."

Glaxo Wellcome also provides dedicated World Wide Web sites so customers can access data at any time. "The Web site is maintained by a data warehousing organization. Glaxo Wellcome doesn't have access to it. We only see aggregate reports," he explains.

Customers can visit the Web site and select the report they want to view from a table of contents. "They can get on the Web and see that John Doe attended ASMP classes one, two, five and six. They can check John Doe's utilization. That level of detail is available, if the customer wants it." ■

Picture of Health

Here s a look at 12-month outcomes for 117 participants in the Asthma Self Management Program developed by Glaxo Wellcome Care Management in Research Triangle Park, NC:

77.9% decrease in days hospitalized for asthma;
48.8% decrease in asthma-related ER visits;
32.5% decrease in asthma-related urgent care visits;
6% decrease in scheduled office or clinic visits for asthma-related issues;
55.1% decrease in days of work, school, or usual activities lost due to asthma;
76.2% decrease in less-productive days at work, school, or usual activities due to asthma;
13.9 average gain in productive days;
mean number of nights awakened due to asthma dropped from 1.3 per week at baseline to 0.67 per week at one;
21.2% increase in emotional well-being;
20.8% increase in social activity;
24.6 % increase in daily work activity;
22.6% increase in physical activity.

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HMOs plan to raise senior member rates

Higher rates expected to reduce Medicare revenue

Health maintenance organizations plan to raise Medicare member premiums, decrease benefits, and reduce provider compensation in response to reduced Medicare revenues per member resulting from the 1997 Balanced Budget Act (BBA), according to a recent survey by Milliman & Robertson's Milwaukee office. What HMOs say they won't do is reduce Medicare member growth.

The 1998 Intercompany Rate Survey, now in its seventh year, includes data from roughly 40% of all HMOs in the United States. Other changes HMOs surveyed plan include lower prescription drug benefits, strict use of formularies to control drug costs, and designing and operating risk pools with incentives based on objective quality measures.

The BBA caps government payment rates to HMOs at an increase of 2% annually until 2003, compared to recent average annual increases of about 7% to 10%. ■

AUA launches fight against incontinence

Urinary incontinence is a common medical problem that affects half of all women at some point during their lives, according to the American Urological Association (AUA) in Baltimore. Many women fail to get help due to embarrassment and widespread ignorance of the many successful treatments and cures now available.

AUA launches a public awareness campaign in December 1998. The effort includes a toll-free number for public information about incontinence and its treatment: 877-dry-life [(877) 379-5433]. Consumer information also is available on the campaign's Web site at www.drylife.org. Also, AUA published a brochure, *You Are Not Alone: A Step-by-Step Guide to Treating Incontinence.*

For additional information, or a copy of the brochure, visit the campaign Web site or contact: AUA,1120 N. Charles St., Baltimore, MD 21201. Web site: wwwauanet.org. ■

CE objectives

After reading this issue of *Case Management Advisor,* continuing education participants will be able to:

1. Implement strategies for creating public awareness of case management.
2. Recognize signs of long-term domestic abuse.
3. List common reasonable accommodations for psychiatric disabilities.
4. Identify elements of a wound management system.