Case Management ADVISOR™
Covering Case Management Across The Entire Care Continuum

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Case management assistants free up case managers for clinical tasks

Teamwork is the key to program's success

At Hudson Health Plan in Tarrytown, NY, case management assistants who handle non-clinical tasks that don't have to be done by a licensed professional are freeing up the nurse case managers for jobs that require their special clinical skills.

Hudson Health Plan is a not-for-profit managed care plan servicing more than 80,000 members in the Hudson Valley of New York.

"Case managers didn't go to school to do data entry and they like having help with the front-line things so they can spend time on other duties. Having case management assistants allows our nurses to carry a larger caseload and still have time to give the members the attention they need," says **Margaret Leonard,** MS, RN-B, C, FNP, senior vice president for clinical services.

Each program at Hudson Health Plan has a case management assistant assigned to work with the case managers in that program.

The case management assistants work closely with the nurses in the individual programs to which they are assigned. They are cross-trained so they can work in any program and with all populations.

"At this point, we are operating in silos. Nobody can learn one system and plug into any population. The case management assistants are knowledgeable about all the programs so they can fill in whenever they are needed," Leonard adds.

Most of the case management assistants have some college education and experience in health care or customer service. Many have worked for private physician practices or at health centers. All are bilingual.

"These are people with myriad talents. Some are experts in technology. Others have terrific people skills and are able to engage members on the telephone. All of them are eager to learn and have been cross-trained so they can perform any of the jobs in any areas of the case management department," Leonard says.

The case management assistants are enthusiastic about learning more

about the programs that Hudson Health Plan offers and are always willing to take on more responsibility, she says.

"When they take on a new task, we make sure we create scripts and standards so that everyone is giving out the same correct information," she says.

Here's an example of how the program works:

The asthma management program is staffed by one nurse case manager and one case management assistant who work together to coordinate care for members with asthma who meet the criteria for case management.

The health plan uses data from its claims system to perform the first layer of stratification for members with asthma who may be eligible for case management. The department receives a report listing everyone who has had an emergency department visit or been hospitalized for asthma as well as people who are taking medication for asthma.

The nurse case manager and case management assistant divide up the list according to the language spoken by the member.

The bilingual case management assistant calls the Spanish-speaking members and conducts the initial information-gathering assessment.

If a Spanish-speaking member meets the criteria for the program, the case management assistant transfers the member to the case manager for a clinical assessment and acts as a translator or sets a time when both can call the member.

When providers call for approval for a treatment or hospitalization, the case management assistant takes down the information and enters it into the system. If the case falls under the health plan's set criteria, the case management assistant has a script to use for issuing the approval. If the procedure is not on the list of approved procedures or more clinical information is needed, he or she will transfer the call to a nurse.

"The case management assistants are skilled at recognizing when they have reached the limits of what they can do to help the member and knowing when to triage the member to the appropriate personnel," she says.

The case management assistants work on the outreach portions of the program as well as handling some of the front-line intake and data entry.

They make outreach calls to members in the program to which they are assigned after discharge from the hospital. They ask members if they understand their discharge plan, if they have gotten their prescriptions filled, and if they have made a follow-up appointment with a primary care physician.

"When people are in the hospital, they are under stress and may miss some aspects of the discharge plan. This gives them another opportunity to ask the questions they didn't ask in the hospital," Leonard says.

If the member has clinical questions, the case management assistant refers them to a nurse.

"This makes the case management assistant's job more interesting. They do far more than data entry. They are trained to conduct outreach calls and to engage with members. This gives them

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that feeling of satisfaction that comes from helping someone," she says.

The department also has project coordinators, case management assistants on another level, who work with the nurses to collect and retrieve data from the health plan's information system for various projects.

Every morning, everyone in the department participates in a "stand up meeting" during which the staff discuss what they are working on, if they need help on a particular project, or if they are available to help.

"Our case management assistants are the best. Everyone in the department has a good working relationship with each other and we help each other out when needed," Leonard says.

(For more information, contact Margaret Leonard, MS, RN-B, C, FNP, senior vice president for clinical services, Hudson Health Plan, e-mail: mleonard@HudsonHealthplan.org.) ■

Program gets ill, injured patients back to work

Proactive approach helps health plan exceed

The award-winning medical and disability case management program developed by Blue Cross and Blue Shield of Texas has shown a significant impact in getting employees back to work in a timely manner.

In the first year of the program, more than half of the participants returned to work earlier than expected, based on national averages for their type of injury.

"Statistics show that the longer an employee remains off the job, the less likely he or she is to ever return. The key to our success is that we begin coordinating the care of members early on in their illness and injury and ensure that they get all the services they need to recover and go back to work, says **Patricia Sumner**, RN, BA, CCM, COHN-S, disability nurse case manager with Blue CareLink Disability Case Management.

For example, after six months of disability, the worker's chance of not returning to work is about 50% and after nine months, the figure climbs to 90%, she adds.

The program has received a BlueWorks Award from the Blue Cross Blue Shield Association for its success in decreasing the time that injured or ill patients need to return to their job, reducing costs and increasing employee productivity.

The Richardson, TX-based health plan started the disability case management program in 2005 to help members who are ill or injured get well and back to work as soon as possible.

The program emphasizes early intervention and coordination between the medical benefit and the disability carrier as well as proactive patient management across the spectrum of care, Sumner says.

Before the program, injured and ill members were eligible for case management but there was limited coordination with the disability carriers, Sumner points out.

Most members enroll in the volunteer program after they file claims for short-term disability. However, in the first year, 24% of participants entered the program before they filed a claim.

Those members were identified through the health plan's predictive modeling, which mines claims data to identify members who have the benefit through their employer and who have an illness or injury that is likely to result in a short-term disability.

Other members are referred by their disability carrier or by referrals from other Blue Cross and Blue Shield of Texas programs.

"The beauty of this program is that through our internal processes and predictive modeling, we identify members as early as possible and can start them on the road to recovery earlier," she says.

For instance, real-time referrals identify members who have had a recent hospitalization for catastrophic injuries, such as those who have suffered a stroke or have been involved in a motor vehicle or other type of accident.

The predictive model identifies those who are at risk for joint replacement surgery, such as members who are older, are taking anti-inflammatory medications, or are receiving frequent physical therapy.

"By identifying them in the early stages of their illness or injury, we can see that they receive appropriate care by the right providers, help them understand and adhere to their treatment plan, and make sure they know how to file for disability benefits if they need them," she says.

If the member needs to file for short-term disability, the case managers can help them do so.

"If they need help with community resources, we help them find what they need. We work in any way possible to help them get moving and

back to work," Sumner says.

If they have complications or comorbidities, the case managers also refer them to other Blue Cross Blue Shield of Texas programs.

If patients aren't appropriate for the disability management program, the case managers refer them to programs where they can get assistance.

For instance, if the disability carrier refers a member with a spinal cord injury to the program, the disability case manager would refer him or her to the catastrophic case management programs so the patient can get the help he or she needs, she says.

The program's focus is on early intervention with members who are likely to file to have a temporary disabling condition and are likely to be able to return to some type of employment within six months after their injury or illness.

The majority of members are in the disability case management program for a maximum of six months.

The care for catastrophically injured or more seriously ill patients who will need more long-term management is coordinated by the company's catastrophic case managers.

When members are identified as eligible for the program, they are contacted by a disability case manager who offers them the option to enroll.

When members enroll, they work with the disability case manager to define their goals.

"We want to ensure that realistic and appropriate treatment, financial, and psychosocial needs are identified and met. Our goal is for the patient to achieve maximum health benefits and be able to return to work," she says.

The disability case manager works with the physicians and other medical providers to coordinate the plan of care and treatment plan and ensure that the ill or injured worker receives timely assessments and referrals for necessary medical, surgical, and/or rehabilitation services.

At the same time, the disability case managers work with the patient, helping him or her comply with the treatment plan and ensuring that he or she is progressing according to expectations.

The interventions are based on standard guidelines for treatment of the patient's condition, the severity of the injury or illness, and the patient's progress.

The case managers use national standardized measurements, such as the Workloss Data Institute's Official Disability Guidelines, to develop their plan of care. The guidelines include evidence-based medical treatment guidelines and an estimated time of duration of each condition, allowing the case managers to track the patient's progress.

The program integrates the health plan's medical management and disability management program. The disability case managers are able to access the claims system for the disability carrier to determine patient demographics, physician contact information, and claims status.

Case managers add current case management notes to the system, allowing the claims handler to expedite the processing of the patient's return-to-work status.

"The disability case management program addresses any medical and psycho-social needs of the patients with interventions that assist them in moving efficiently and facilitating early return to work" Sumner says.

For instance, when appropriate, the case managers refer the members to a mental health provider or their employee assistance program for help with mental health issues.

"Statistics reveal that depression and other mental health disorders may be brought on by a potentially disabling physical illness and progress toward recovery depends on early treatment of mental health issues," she says.

When the case managers talk with the members, they identify what other comorbidities they may have and refer them to other programs that are part of the medical plan.

For instance, if a member has had a stroke and has hypertension, the case manager would link the patient with the health plan's wellness initiative, which would help the patient get his or her blood pressure under control, come up with an exercise and weight loss plan, if needed.

"We want to create a continuum of care so once we have gotten them through the process of getting back to work, they can continue with the other wellness programs and stay healthy," she says.

The case managers help members connect with community support programs, such as those provided by the American Cancer Society. They also provide the member with access to resources available through their company's employee assistance plan.

The disability management team coordinates with all other programs offered by the health plan, including the wellness initiative, catastrophic case management, and specialty programs such as disease management or behavioral

health management.

When appropriate, the member is co-managed by the disability case manager and a case manager from a disease management and behavioral health management program.

"An integrated medical and disability management program promotes early identification of patients with conditions that may place them at risk for prolonged disability. Our wellness initiative programs, predictive model tool, and trigger diagnosis reports allow us to identify and reach out to members and provide them with tools that may help them maximize their health benefits and minimize or prevent a permanent disability," Sumner says.

(For more information, contact Patricia Sumner, RN, BA, CCM, COHN-S, disability nurse case manager , Blue Cross and Blue Shield of Texas, e-mail:Patricia_Sumner@BCBSTX.COM.) ■

Coordination of care helps patients manage disease

Chronic care model links providers, community

The only way to help people with chronic illnesses manage their disease is to develop a care management protocol that extends through the entire disease process from the acute care episode to the community and back to the acute care facility, says **Donna Zazworsky**, RN, MS, CCM, FAAN, manager of network diabetes care, faith community nursing and telemedicine for Carondelet Health Network in Tucson, AZ.

"So often we work in an organization where patients come in because they're already sick and we are reacting to what is presented. We need to develop ways to be proactive and screen people ahead of time to identify those who are at risk for a disease to help them avoid it and to help those with the disease keep it under control," Zazworsky says.

Case management across the continuum is the key to helping people manage their chronic diseases and keeping them out of the hospital, she adds.

"Evidence suggests that providing high-quality chronic care involves more than just adding additional interventions; linkage between the health care delivery system and the community plays a big role," she says.

For a treatment plan to succeed, health care providers must link the patient to outside resources such as exercise, weight management, and diabetes programs and collaborate with staff at community organizations and agencies to coordinate care, she adds.

"Everyone needs to work as a team to coordinate patient care. We need to all know our roles and tasks," she says.

Zazworsky is a proponent of the chronic care model, which extends health care beyond the provider or health plan and incorporates community-wide efforts to improve clinical outcomes.

For instance, in Tucson, St. Elizabeth Health Center, a faith-based community health center serving the uninsured and underserved, has collaborated with other community agencies and developed a comprehensive program for diabetics that provides recommended care at a reduced cost and co-pay.

The chronic care model is an evidence-based model that takes an organized approach to treating people with chronic diseases and emphasizes the patient's role in managing his or her disease, Zazworsky adds.

The model extends care beyond the health care system and into the community to provide better functional and clinical outcomes, she says.

"The issues related to the cost of chronic care are profound," Zazworsky points out.

For instance, total diabetes spending tops $98 million in a year, she says. A person without diabetes incurs an average of $2,669 in health care costs each year. Health care for diabetics on average cost $10,071 a year.

Each year, diabetics have a mean hospital stay of 5.4 days, for a total of 13.9 million days and a cost of $72.5 billion. Patients make 30.3 diabetes-related visits to the doctor each year and generate $10.9 billion in outpatient costs.

Americans with diabetes account for 15% of national health care costs although they make up only 5% of the population, Zazworsky adds.

An additional 15% to 20% have undiagnosed impaired fasting glucose, impaired glucose tolerance, and gestational diabetes, she says.

The problem is compounded by the fact that the prevalence of the disease is increasing at a rapid pace, she adds.

In 1994, there were 99 million people worldwide with diabetes. That figure is expected to rise to an estimated 215 million by 2010.

However, there is a solution to the problem, she adds.

A three-year study of a comprehensive care program showed that diabetics who were closely monitored achieved a 26% decrease in inpatient days along with a 10% decrease in length of stay. Specialty visits decreased by 25% while pharmacy costs increased by 16% due to increase use of medications. Overall, the program achieved an 11% decrease in costs, Zazworsky says.[1]

An effective chronic care program takes a proactive, rather than a reactive approach to care, Zazworsky points out.

To develop a chronic care model in your organization, start by looking at the population you serve to determine how to design the program, Zazworsky advises.

Look at the diagnoses of your patients, how you treat the disease, and how you manage complications. Follow the disease process to the acute care episode and back and look at ways to minimize the progression of the disease, she says.

"We need to develop ways to assess patients to identify those with no disease who are at risk and if they do have a disease to look at what kind of interventions they need," she says.

Examine how the organization of health care is established within your hospital, health system, or health plan. Look at the goals, incentives for providers, process improvements, and strong senior leadership support.

Look at effective programs in the community as well as within your organization, she suggests.

Research the resources available within your community including non-profit organizations, health plans, and governmental agencies such as local health departments.

Develop agreements that facilitate care coordination within and across organizations in your community, she adds.

Create formal partnerships among organizations in the community so you clearly understand what your relationship will be. Come up with a contact person at the agency.

Compile a list of community resources that can be used to help patients find resources that can help them manage their diseases, she says.

For instance, the diabetes St. Elizabeth Health Center created a list of agencies that offer walking and exercise programs as well as places where patients could go for low-cost diabetes supplies.

Within the delivery system, look at the roles of the team. Do you have planned visits to deal with chronic illness? How do you continue the care, handing off the patients from the hospital system to other providers in the community?

Look at each cost component of the program and determine what costs may be a barrier to patients. Look at the barriers to people in your community receiving care, she says.

"You need as an organization to determine how you can influence the cost of care for the uninsured," she says.

An effective chronic care program needs a clinical information system that maintains comprehensive information about patients, their conditions, and their adherence, she says.

For instance, you should be able to pull up a subgroup of patients with diabetes and a co-morbidity of congestive heart failure who are female and age 40 and older.

You should track how often the patients are hospitalized or visit the emergency department and whether they are filling their prescriptions or having the recommended tests and procedures.

A successful chronic care model means working with health plans and payment systems to identify people early and get them into the right program and offering incentives for providers who treat patients more effectively, she says.

A chronic care program is an opportunity for health plans and provider to work together and share data on the patients, so you can generate care reminders about gaps in care, she says.

For instance, health plans have partnered with providers to ensure that patients with chronic diseases receive evidence-based care and are treated effectively through pay-for-performance models and efforts to ensure that patients have a patient-centered medical home, she says.

When your program begins, use the continuous quality improvement (CQI) process to evaluate and improve delivery, she says.

"CQI can improve performance, enhance productivity, enhance patient care, and increase cost effectiveness," she says.

The American Diabetes Association (www.diabetes.org) offers a wealth of resources that can assist health care professionals in developing a program, she says.

Zazworsky also recommends the Case Manager Adherence Guidelines developed by the Case Management Society of American (for details see www.cmsa.org), which help providers assess a patient's readiness to change.

(For more information, contact Donna Zazworsky, RN, MS, CCM, FAAN, manager of network diabetes care, faith community nursing and telemedicine for

Carondelet Health Network in Tucson, AZ. E-mail: donnazaz@aol.com.)

Reference

1. The New Economics of Diabetes Management, presented at the 60th Scientific Session of the American Diabetes Association, June 20, 2000. ■

Make written material easy to read, understandable

Plain language documents suitable for 80%

What makes educational material a must-read? The key is to make documents easy to read and understand, says **Doug Seubert**, guideline editor in Quality Improvement and Care Management at Marshfield (WI) Clinic.

"You can have a document that is easy to understand, all the medical terms are defined, and there are even good diagrams that 'show' what the text is 'telling.' However, if the font is too small, there is little white space, and the information is not broken into sections, it may be too hard to read and the majority of patients won't even try reading it," explains Seubert.

The reverse is also true. A document that has a larger font, uses white space and bullet points to break up the text, and is in a two-column layout may have medical terms that are not explained and long, wordy sentences that make it difficult for most people to understand, he adds.

"If a pamphlet looks hard to read, people will not read it. If they try to read material and find long words and medical jargon, it is difficult for them to get through, or they don't see how the information will help them, they will throw it away," says **Sandra Cornett**, PhD, RN, director of the OSU/AHEC Health Literacy Program at The Ohio State University in Columbus.

Effective educational materials must be easy to read and easy to understand—the two cannot be separated, says **Linda Benn**, RN, BScN, patient education coordinator at QEII Capital Health in Halifax, Nova Scotia, Canada.

Easy-to-read material is written in plain, everyday language and flows well from one topic to the next. The content is of interest to the reader. Easy to understand applies to comprehension and whether the reader can explain what he or she just read—for example, if he or she can list the steps in correct order for drawing up insulin, explains Benn.

Written materials that are easy to read share several characteristics, and the same is true of articles that are easy to understand.

What do easy-to-read materials have in common?

Reading grade level is part of the process of making a document easy to read. Readability formulas are used to help assess the reading difficulty, which has to do with such factors as the number of syllables in a word and the number of sentences in a paragraph, says Cornett.

Grade level only a beginning

"Reading grade level is a good start, but readability is more than that. You can put together gobbledygook made up of short words and sentences, and have a very low reading grade level but a useless document," says **Janet Sorensen**, a writer for the Arkansas Foundation for Medical Care in Little Rock.

Design elements contribute to readability, she adds. Use a 12-point font or larger if readers may be visually impaired. Serif fonts, such as Times New Roman, work well for the body of the text, because these fonts are easier to read. San serif fonts, such as Arial, can be used for headings and subheads.

White space, or areas without text, add to the readability of written material. "It's recommended that 30% to 50% of a document should be white space. This includes margins, spaces between paragraphs and lines of text, and space around graphics and photos," says Seubert.

The length of the lines of text on a page impacts the readability of a document. Lines of text that span across the page make a person's eyes work harder as he or she reads. On a standard 8.5"x11" page, a two-column layout is recommended, or the margins on a single-column layout should be increased so the lines of text are between 50 and 70 characters, says Seubert.

Breaking the information into sections or "chunks" makes a document easier to read, because the eyes can scan the document and focus on each section. Using lists helps break up text and makes key points stand out. "Lists can be bulleted or numbered. Numbered lists should be used for directions or instructions that require a series of actions that must be done in order," says Seubert.

Design should not be an afterthought but part of the entire writing process, says Cornett. How the information is to be structured with subheads and sections makes the information more readable.

Layout and design also can make a document easier to understand. Subtitles help guide the reader to the important information. Organizing the material under subtitles also will help the writer limit the information to three to five important points. "Too much information is overwhelming, and the reader will not remember any of it," explains Cornett. **(To learn how to target the intended audience see article on field testing, see article on pg. 141.)**

In order for headings and subheadings to be useful, they must be written clearly, so readers can find the information they want. "Labeling a section 'symptoms' or 'what to do' may not be clear to the reader. Headings should serve as a summary of what is covered in that section," explains Seubert.

One of the most effective ways to write clear headings is to use the question and answer format, he says. For example:

- What is high blood pressure?
- What causes high blood pressure?
- How is high blood pressure treated?

This technique helps the writer focus on one key piece of information at a time and provides natural breaks in the document to separate the sections. Also, it helps readers scan through the document and find the information they need.

Creating understandable content

To make sure documents can be understood by the reader, they must be written in plain language. This is clear, simple, direct writing using only as many words as necessary to state a point.

"Plain language also avoids jargon and instead uses common words that are easier to understand," says Seubert.

For example, "chest pain" is used instead of "angina." Yet authors need to make sure medical jargon does not creep into the text. "Often I see words like 'chronic' and 'acute' used in a document without being defined. Or a phrase like, Call your doctor if your child exhibits any of the following symptoms.' Since the majority of health information for patients is written by health care professionals, it's easy to slip into medical jargon without even knowing it," says Seubert.

Words like consistent,' observation,' modify,' and intake' are common in health care documents and writers need to watch for them, determine if they are necessary and if there are easier alternatives, he adds.

"The words, even the one-syllable words, need to be familiar to your audience. If they're not, and you must use them, define them as clearly and simply as possible," states Sorensen.

Medical terms do not need to be included in the text if there is a common term that means more or less the same thing, continues Sorensen. For example, "heart attack" can be used rather than "acute myocardial infarction." If a medical term is used, it needs to be defined as clearly as possible. "The definition might need to be a separate sentence to keep the sentence from getting cumbersome," she adds.

Benn states that she often uses a definition with a medical word or difficult word she cannot eliminate or change, because doing so would change the intent of the brochure.

Cornett says she likes to put the lay term first in the sentence with the medical term after; however, she does not place it in parentheses because people with limited literacy do not always understand that grammatical practice. Instead she would write: "a heart attack, or what some doctors call an acute myocardial infarction." In this way the reader would not stop at a medical term he or she is not familiar with, and when the word does come up in the sentence, the reader can skip the word without altering the meaning of the text.

When writing content, keep the tone friendly and involve the reader using pronouns such as you', we,' or us,' advises Benn.

A personal approach draws in the reader, agrees Seubert. Instead of writing, "People with diabetes should examine their feet every day," write, "Because you have diabetes, it is important to check your feet every day," he explains.

It's also important to write in active voice rather than passive voice, he adds. Active voice is more direct: "Your doctor may prescribe some medicine to help control your blood pressure." Written in passive voice it might read: "In order to help control your blood pressure, some medicine may be prescribed by your doctor."

Photos, diagrams, and drawings help to explain the text as well, says Seubert. However, any photos or drawings that are used should be labeled and placed close to the appropriate text in

the document.

Surveys show that people of all education levels prefer information that is clear and easy to understand. Therefore, documents written in this manner will be suitable for about 80% of a patient population. This is the concept of universal design, explains Seubert.

"Universal design is fairly prevalent in our society, and we often take it for granted. Handicapped-accessible doors at grocery stores and other public buildings are a good example. They provide access to everyone equally, and we all benefit from the convenience," states Seubert.

Therefore elements that make documents easy to read and easy to understand can be universally applied to health care information, and as a result handouts will fit the majority of patients. ■

Field testing, a must-do for on-target handouts

Find out what audience wants to learn

To write clear, understandable material for patients, patient educators must involve the target population in the process.

It's important to find out how the intended audience perceives the topic, and what their concerns are so the material can be written from their perspective, says **Sandra Cornett**, PhD, RN, director of the OSU/AHEC Health Literacy Program at The Ohio State University in Columbus.

There are two different times to involve potential readers. The first is before you begin to write the material, and the second is when the article is completed.

Before writing an article, ask potential readers what they want to know about the topic, so the message can be framed from a patient perspective. In this way, it will grab their interest and address their major concerns. That doesn't mean that health care professionals don't include information they see as essential, such as facts on self care, that weren't mentioned by potential readers. However, patients' concerns must be addressed as well, explains Cornett.

Once the final draft is completed, field test the material either in a focus group or one on one. "There is no other way to find out if the material is understandable until you take it to your intended user," says Cornett.

During field testing, you will look at content to determine if the audience can read, understand, and remember key points.

A second area of focus is utility. Will the audience read the materials and use it? Is it culturally appropriate?

The third area of testing is on appeal. How does the audience respond? Is the piece attractive, persuasive, easy to read, personally relevant?

How to field test

To field test, start with general questions. Ask readers, "What are some words to describe this pamphlet? What do you like best about this piece?"

Continue with questions on content, writing style, layout and design, and the use of the material. Questions in these categories may include:

Content—

What are some of the major ideas?

Are any ideas confusing?

Are important ideas left out?

Are people with similar problems likely to be concerned about these ideas?

Writing style—

Are there words you don't understand?

What do you think about how the ideas were presented?

How about the length of the piece?

Do the words sound the way people talk?

Layout and design—

What do you like/dislike about the way the material looks?

Do the pictures help get the ideas across?

Are there any pictures you would change?

Using the information—

Can a person reading this booklet do what it recommends?

It's important to field test before having a pamphlet printed or an educational sheet downloaded onto the Intranet, because it is the only way to be sure patients will read and follow the information, says Cornett.

(*Editor's Note: For additional information on field testing see article on OSU/AHEC Health Literacy Program Web site titled "The Basics of Audience Research and Field Testing." It is located at http://medicine.osu.edu/ahec/4977.cfm under Clear Health Communication Content.)* ■

Get office workers up and moving

Instead of "economy class syndrome," should deep vein thrombosis (DVT) be called "sitting at a desk all day syndrome?" According to new research, prolonged sitting at work is linked to double the risk of DVT and pulmonary embolism.[1] And, the more hours you sit with out getting up, the higher your risk, say the researchers. Each additional hour spent sitting without getting up increased the likelihood of blood clots by 20%.

Encourage workers to get up from their desks at least every hour, avoid sitting in cramped conditions, and move their feet and legs while seated, says **Richard Beasley**, one of the study's authors and a researcher at the Medical Research Institute of New Zealand.

"These measures should contribute to a significant reduction in risk of venous thromboembolism associated with prolonged seated immobility at work," says Beasley.

It stands to reason that any job which requires sedentary activity increases the risk of DVT, says **Deborah V. DiBenedetto**, MBA, RN, COHN-S/CM, FAAOHN, president of DVD Associates in Battle Creek, MI. "Have workers get up and leave their work stations to take a walk and stretch their legs, as well as [do] exercises to avoid carpal tunnel and tendonitis which are associated with desk tasks," she says.

Occupational health professionals need to make the workforce, their dependents, and retirees aware that sedentary activities increase risk of DVT and its complications, including pulmonary emboli, says DiBenedetto.

"Ergonomics programs for office workers should include 'get up and go' activities to spur individuals to change positions at least hourly and keep the circulation moving," says DiBenedetto. "Knowing that we work for longer periods of time, often 10 or 12 hours sitting at our desks, with three or four hours at a single stretch, we need to get moving and take a break from our sedentary positions."

To prevent DVTs, DiBenedetto says that workers should stand at their workstation and stretch their legs, arms, and torso, and take a short walk every 30 minutes. Ask workers to rotate their feet in small circles, or write the alphabet with their feet elevated in the air every hour.

"It is imperative to not cross your legs and impede blood flow," she says. "DVT is avoidable, as are ergonomic injuries in the workplace. Both require worker training and engagement, with organizational support to ensure success."

Reference

1. West J, Perrin K, Aldington S, et al. A case–control study of seated immobility at work as a risk factor for venous thromboembolism. *J Royal Med Soc* 2008; 101:237-243. ■

How big is the DVT risk, really?

Although a new study says that sedentary workers double their risk of deep vein thrombosis (DVT), it's difficult to gauge the true risk of DVT, according to **Monika Fischer**, MN, RN, APRN BC, CCM, COHN-S, FAAOHN, health services administrator for the City of Glendale, CA. For one thing, Fischer points to the "extremely small sample size" in the study and other confounding factors.[1]

"These people could have co-morbidities that increased their risk, as well as significant family history," says Fischer. "Further, more in-depth studies need to be done before any company will start to think this is a serious enough problem to address it with special programs."

Fischer also points to the 612 million people flying each year who average about 1,046 miles per trip. "So let's say that we took a quarter of them and said they went on 'long-haul flights,' — that would end up with about 32 million cases of DVT, a much more significant number," she says.

Fischer also notes that only about 21% of the total workforce work in sedentary jobs. "And I would imagine many of them require that they move around regularly throughout the day," she says. "I do concede that people like dispatchers have problems."

Fisher says that the City of Glendale has done extensive ergonomic evaluation on all police and fire dispatchers and made extensive changes. "Hi/lo" desks are provided that move up and down on hydraulics. Employees can stand or sit while working, and booklets on exercises to do while seated were distributed.

"We haven't had a significant population with problems," says Fischer. "And since I have

been here, we have never had a dispatcher with a DVT."

Reference

1. West J, Perrin K, Aldington S, et al. A case–control study of seated immobility at work as a risk factor for venous thromboembolism. *J Royal Med Soc* 2008; 101:237-243. ■

Tips for reducing employee stress

Employees rank time pressures, deadlines, office politics, and their bosses as the top stress-inducing factors at work, according to a new workplace wellness survey conducted by Eclipse gum and the Institute for Corporate Productivity (i4cp).[1]

Employees can use small tools to beat stress at work, such as going outside for a breath of fresh air, closing their eyes while slowly counting to 50, or chewing gum. A study presented recently at the 10th International Congress of Behavioral Medicine examined the effects of chewing gum in response to a stressor. [2] It found that the use of chewing gum was associated with reduced stress, improved alertness, and relieved anxiety.

I4cp recommends these other tips to help relieve office stress and increase employee efficiency:

- Company-sponsored social activities can help take the edge off. Survey results showed that the more social activities employees attended, the less stress they reported.
- Employees can re-energize before the next task by taking an afternoon walk around the office.

References

1. Institute for Corporate Productivity. Workplace Stress Survey 2008. Seattle. 2008.
2. Scholey A. An investigation into the effects of gum chewing on mood and cortisol levels during psychological stress. 10th International Congress of Behavioral Medicine. Tokyo, Japan. August 2008. ■

COMING IN FUTURE MONTHS

- Strategies for helping seniors remain healthy
- Managing the care of the indigent
- Are you providing culturally competent care?
- Collaborative care through the continuum

CE questions

21. All the case management assistants at Hudson Health Plan are bilingual.
    A. True
    B. False

22. In the first year of Blue Cross and Blue Shield of Texas' case management disability program, what percent of patients returned to work earlier than expected?
    A. 25%
    B. 50%
    C. 55%
    D. 75%

23. According to Donna Zazworsky, RN, MS, CCM, FAAN, a person with diabetes incurs an average of about $10,000 a year in health care costs.
    A. True
    B. False

24. According to Doug Seubert, guideline editor in Quality Improvement and Care Management at Marshfield (WI) Clinic, what percentage of written educational material should be devoted to white space?
    A. 5-10%
    B. 25-45%
    C. 30-50%
    D. 50-65%

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

CE objectives

After reading this issue, continuing education participants will be able to:

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

CE instructions

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

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