Case Management ADVISOR™

Covering Case Management Across The Entire Care Continuum

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IN THIS ISSUE

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CMs, DMs collaborate to coordinate care for Medicare Advantage members

Software system integrates support, avoids duplication

At a health insurer in the northwest mountain state region, case managers and disease managers work hand in hand and share an electronic care management software system that allows them to seamlessly manage the care of their Medicare Advantage members.

The health plan implemented a new software system in May that allows the disease managers, the case managers, and the behavioral health staff to operate on the same platform.

"We have easy access to information on any member. This enables us to integrate the support that we offer our members and avoid duplication," says **Sharon Arneson**, RN, CCM, manager of case management and disease management.

Before the new software was implemented, the case managers and disease managers communicated by telephone and e-mail.

"Now, we can move between the programs to meet whatever is the need of that member at that particular time," she says.

The health plan's goal is to ensure that members get the right services at the right time and in the right place, says **Doug King**, MSW, LCSW, MBA, manager of supplemental programs.

Members can be in disease management and have a case manager at the same time, he adds.

Case managers provide complex care management services for members who are in the hospital or a post-acute facility; who have an illness or injury that requires a complex treatment plan; or who have been diagnosed with serious medical conditions such as cancer and need help choosing the best treatment options, King says.

"Members don't have to be chronically ill to qualify for case management. They just have to be in a situation in which they need a health care advocate," King says.

Regence offers disease management programs for individuals with congestive heart failure, chronic obstructive pulmonary disease,

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asthma, diabetes, and coronary artery disease.

They screen these members for depression and anxiety since there are high comorbidities for people with chronic conditions and may refer them to the health plan's behavioral health team.

If a member in disease management is having an acute issue or other complex needs or ends up in the hospital, the disease management team calls in a case manager.

"Sometimes we will co-manage the member, or the disease management nurse will just be in a holding pattern while the case manager works with the member," he says.

At the same time, when the case managers are working with members with complex needs and determine that they have conditions covered by the disease management program, they make a referral to the disease management team.

The disease managers and case managers also can refer members for health coaching if they need to lose weight, stop smoking, or need help with other lifestyle issues.

"If members need to be co-managed, having all the information on one platform makes it much easier. When the nurses or behavioral health specialists document in the case notes, the disease managers have instant access to it. We can see the treatment plan, what goals have been set, what interventions have occurred, and when the case manager has contacted the member last," Arneson says.

Members also like the process since they no longer have to repeat the same information to the case managers that they gave to the disease manager, she adds.

Members are referred to case management when they are hospitalized or have an emergency department visit and from the company's utilization review nurses when providers request certain types of complex services. In addition, members may refer themselves for case management, or family members may refer them.

"If it's a self-referral or a family referral, they receive automatic approval for the program. If members request it, we will enroll them and help them with whatever issue they have," King says.

The health plan also uses predictive modeling to identify members who could benefit from case management.

For instance, members who have an orthopedic issue and a history of falls would be triggered for case management.

"We would make sure they have the right durable medical equipment and that they receive occupational therapy or physical therapy if appropriate. Our purpose is to reach out and make positive interventions to prevent future health care problems from emerging," King says.

When members are hospitalized, the Regence case managers work closely with the hospital utilization staff to ensure that the members get the care they need, he adds.

"We use Milliman Care Guidelines to examine what condition the member has, what care is being provided, and to actively and assertively assist in driving the care," he says.

For instance, if a member has a pacemaker installed on Friday and is being kept in the hospital over the weekend for monitoring, the case manager

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intervenes if evidence doesn't show that the patient needs to be monitored in an acute care setting.

"In this case, we would make sure that the member needs continuing acute care and isn't just sitting in the hospital over the weekend. It's a matter of ensuring that our members are getting the right care at the right time," he says.

They conduct concurrent reviews to ensure that the patients are receiving the services that they need and are in the right level of care.

"We look at whether a member could get the care he or she needs at a skilled nursing facility or a long-term acute care hospital. If we can get the member the right care in the best setting, we can help lower their out-of-pocket expenses or copayments," he says.

Case managers interact with members and their families as well as providers.

Explaining continuum of care

"We try to address the issue of continuum of care, explaining to the family why members are at the current level of care, and when and where they should receive care in the future. We work with the discharge planners at the facility to help the member transition between levels of care" King says.

Often the case managers educate family members about the various levels of care, explaining why patients need to be discharged from the acute inpatient setting and helping them understand what kind of care they will receive at the next level of care.

"We explain why the member needs to go to the next level of care and show them their financial responsibility if they continue to stay in a facility that Medicare won't pay for. We support the hospital decision to discharge when the chart shows that the patient is ready to go. We don't want the hospital discharging people too early because they come right back," he says.

The case managers advocate for the members with the clinical staff in the hospital to ensure that the member receives recommended care.

If a member is experiencing frequent readmissions for the same condition, the case managers intervene and conduct an assessment to determine the cause. It may be that the member doesn't understand the treatment plan or is unable to follow it and needs help from a health coach or a disease management nurse. Or the case manager may find out that the members didn't receive the post-acute services that were prescribed or that they were inadequate, or, in some cases, the patient was discharged from the hospital too soon.

"We try to be as proactive as we can. The more we are involved, the more it's a win-win effort. If we can help members avoid future episodes of care, it reduces health care costs, reduces their out-of-pocket expenses, and improves the quality of life for our members," King says.

The health plan uses a data mining tool to identify members who are eligible for the disease management program and uses a three-pronged strategy to help them manage their conditions.

Low-risk members are those with chronic conditions who are managing well with no gaps in care and no inpatient stays or emergency department visits associated with the condition or disease.

They receive a welcome letter along with a brochure describing the program and regular educational newsletters. The low-risk members also are offered the opportunity to opt in to the program if they think they need support from a nurse. A low-risk member who chooses to opt in to the program might be someone who is concerned because of changes in his or her blood sugar level or needs support to get on a diet and exercise program.

"Our role is to help the members set healthy lifestyle goals and to provide support for the physician's treatment plan," Arneson says.

Members at moderate risk have a gap in care, such as not receiving a cholesterol screening or a hemoglobin A1c test.

"Every quarter, we have campaigns set up that focus on members with care gaps. We encourage them to talk with their provider about evidence-based care guidelines to ensure that our members receive the full range of services to address their health conditions," she says.

All of the disease managers are RNs and have earned the Certified Chronic Care Professional (CCP) designation.

When a member agrees to participate in the disease management program, the disease management nurse completes a disease-specific assessment over the telephone. The assessment includes information about the member's condition, knowledge of his or her treatment plan, and risk factors.

For instance, if the member has asthma, it's important for the nurse to know if he or she smokes, something that doesn't readily show up in claims data.

They screen all members for depression and coordinate their care with the behavioral health

team if needed.

The disease management program for high-risk members is individualized. The frequency with which the nurses contact the members depends on the members' needs and preferences.

For instance, if a member has experienced an exacerbation in his or her condition or has started on new medications, the nurse may call in frequently. Then, as goals are met, the nurse contacts the member every few weeks, then every few months. ■

Computer-based CCM exam now online

Sign up online, schedule the exam at convenient time

For the first time ever, case managers who took the Certified Case Management (CCM) examination in December could sign up online and take a computerized version of the test.

"We wanted to make it easier to take the examination and renew certification. We felt that we needed to put the application and our database online so case managers could update their continuing education units electronically," says **Vivian Campagna**, MSN, RN-BC, CCM, chair of the Commission for Case Management Certification (CCMC).

Applicants have until Jan. 20 to sign up online for an exam to be given during the first half of April.

The organization began its transition to an electronic product this month and went live with the new system on July 1, 2008.

The CCMC has developed a computer-based platform for the CCM examination, which allows the organization to offer the exam three times a year instead of twice and to increase the number of test sites for the exam from 65 to more than 300.

In addition, case managers may schedule the exam at a convenient time over a seven-day period instead of having to take the exam on just one set day and time.

Applicants may set up an online account where they fill out an application online instead of having to send in paper documents. The system also generates an e-mail to the applicant's supervisor with a link that allows them to certify employment online. A percentage of applicants will be required to send in paper documents as part of the audit process, Campagna says.

The advantage of the web-based product is that applicants don't have to fill out the entire application in one sitting and the process gives applicants an idea if they will qualify to sit for the examination. In the past, applicants had to send in half of their application fee up front but if they didn't meet criteria to sit for the exam, they didn't get their money back.

"If they're not meeting criteria, they won't get far enough to have to pay the fees. The system gives them an idea right up front about whether they meet criteria before they get to the payment screen," she says.

Case managers who are renewing their certification may enter and track their continuing education credits and update their contact information online, rather than handling it by mail.

"We tried to make the process as user-friendly and as easy as possible," she says.

The system has an online chat process during which a live person will answer questions about the application process during certain hours.

The CCMC offers a reference list on its web site to give case managers suggestions for studying for the exam. The organization is certified by the National Commission for Certifying Agencies, which prohibits it from requiring a course book or study guide.

Campagna suggests that applicants visit the CCMC web site and look at the overview of the categories included on the examination to determine areas where they should study.

For instance, if you don't work in the workers' compensation field, you probably need to brush up on that part of the examination.

The test has 180 questions and should take about three hours, she says.

"The test is broadly based because people who are seeking certification come from a wide variety of practice settings. The role and function study that the CCMC performs every five years determines the percentage of questions in each category," she adds. ■

Initiative helps keep uninsured out of ED

CMs help patients connect with PCPs

Case managers at the University of Michigan Faculty Group Practice help low-income indi-

viduals enrolled in a county-supported health plan learn to navigate the health care system and access primary care services so they can stay out of the hospital and the emergency department.

"Many of these patients have never received health care except by going to the emergency department. Many of them don't know how to make an appointment with the doctor for well care or when they are sick. We work on getting continuity of care for these patients. A big portion of our efforts is to educate them to access care appropriately," says **Donna Fox,** RN, health services manager and case manager for University Health System.

The practice, part of the University of Michigan medical school, includes all 1,500 faculty physicians who care for patients at three hospitals and 40 health centers operated by the University of Michigan.

The case managers manage individuals who are enrolled in the Washtenaw Health Plan, a partnership between Washtenaw County, the University of Michigan Health System, and St. Joseph's Medical Center, to provide medical coverage for low-income individuals who do not qualify for other public assistance health care programs.

More than 7,800 county residents are enrolled in the Washtenaw Health Plan, and about half of them receive their health care through the University of Michigan Health System. The two hospital systems absorb most of the cost for the care provided.

The program allows the uninsured to access health care appropriately, to make an appointment with the primary care provider, and to get referrals to specialists for medically required treatment, Fox says.

The case managers receive daily reports of patients covered by the plan who are admitted to the hospital or who have had an emergency department visit.

"We contact the patient to make sure they have gotten their medication, that they have a follow-up appointment with a primary care provider, and that they understand how to use the health system appropriately," she says.

The case managers explain the treatment plan and help the patients follow up so they won't have to go back to the hospital or have an emergency visit.

"Many of our patients simply do not understand how to manage their health care. They are confused by the system and don't know what to do," she says.

A lot of people sign up for the health plan while they are healthy but they don't see a doctor to establish a relationship before they get sick, Fox points out.

Then, when they are sick and can't get in to see a doctor for several weeks, they end up back in the emergency department.

"We help them understand that if they are a new patient, it will take a while for them to get in so they should have a physical and get established with a primary care provider before they are sick. We help teach them that they should see a physician, not go to the emergency room, when they are sick and help them recognize the symptoms that indicate they should call for an appointment," she says.

The case managers are notified when a patient in the program is hospitalized or makes a visit to the emergency department or if they call the health plan with questions, if they can't get an appointment with a doctor, or if they feel their doctor isn't listening to them.

Physicians also call the case managers to help when patients don't appear to understand the treatment plan.

"Sometimes it's a matter of low literacy or they are just so overwhelmed by their illness and their psycho-social issues that they don't understand what the doctor says. They get home and they don't understand what to do so they can call me for help," she says.

The case manager may attend appointments with patients to help them understand what the doctors are saying. They talk to the patient between visits to answer any questions and to make sure the patient is following the treatment plans.

If patients are referred to a specialist, the case managers follow up to ensure that the patients keep the appointments.

If the patients have problems paying for their medication or if it's not in the formulary, the case managers ask the physicians if there is a medication in the formulary that could be substituted. If that's not possible, the case managers help patients apply for a patient assistance program to cover the medication.

"We do whatever it takes to see that patients have continuity in care and that they get the assistance they need," she says.

For instance, they work with the state Medicaid agency to identify community resources, such as housing assistance programs, that can help the patients.

The case managers at both hospitals, represen-

tatives of the health plan, and county agencies meet regularly to talk about the program and how it might be improved.

"We brainstorm on some cases and help each other identify resources that might help our patients. We try to keep in tune with what is going on in the community so we can assist the patients in receiving the help they need," she says.

Most of the patients are enrolled in the health plan at the county health department offices. They choose their provider based on proximity.

The health plan covers the working poor who have some income and may have children. Indigent people who otherwise qualify for Medicaid but don't have a health condition also also enroll.

The program has a limited formulary for medications that includes basic types of antibiotics, statins, and blood pressure medications.

"They picked those that are most prescribed and most cost-effective. These aren't the newest and most expensive medications, but ones that are reliable and frequently used," Fox says.

The co-pay is minimal — $3 for most medications. ■

Follow-up care helps avoid readmissions

Team helps patients navigate health care system

With the number of uninsured patients increasing rapidly, the case management and social work staff at North Broward Medical Center are faced with the challenge of making sure patients receive the follow up they need to stay healthy and out of the hospital.

"In North Broward County, our hospital case managers and social workers work with the district clinics and other providers to make sure our patients have continuity of care after discharge. We try to focus as much as possible on preventive care so these patients manage their health care and reduce readmissions," says **Gavin Malcolm**, LCSW, coordinator of social services and trauma social worker at the Deerfield Beach, FL, medical center.

The hospital has seven full-time social workers, an emergency department social worker, and a trauma social worker, in addition to 20 case managers.

"We work as a team. The case managers and social workers are unit based and work together to determine the patients' needs and how to meet them," he says.

Non-compliance with follow-up care is a huge issue with uninsured patients for many reasons. One issue is that people don't want to go to a clinic and wait for hours, Malcolm says.

South Florida has a large population that doesn't speak English. The hospital has some bi-lingual staff and uses a telephonic certified service to talk to people who do not speak English.

After the hospital implemented a process improvement project to increase compliance with follow-up visits, the percentage of uninsured patients who follow up with their scheduled initial appointment with the clinic rose from 7% to 15%.

"It's still miserably low but it has doubled," he says.

The social workers and case managers use a central scheduling line to set up a primary care appointment before people leave the hospital.

"Because of sheer numbers, there is a long wait for appointments so we try to set an appointment as early in the process as possible. Once they get established in the clinic, they can go there for medication refills without having to have an appointment," he says.

The social workers obtain contact information at assessment and confirm it at discharge so the clinic can call to confirm the appointment, but often, the patients can't be contacted for follow-up.

"Contact information can change on an almost daily basis," he says.

If preventive care is not possible, Malcolm encourages patients to go to an urgent care center, where care may be covered by tax funds, instead of coming to the emergency department. The urgent care centers and primary care clinics result in lower financial burdens on the patients and focus more on the patient's history while the emergency department has to stabilize the patients as efficiently as possible, he says.

"When we make the follow-up appointments, we give the phone number of the patient to the clinic so they can call to confirm the appointment," he says.

Malcolm talks to patients about the benefits of seeing a primary care physician, rather than visiting the emergency department for treatment.

"I point out that they will rarely get the same doctor or the same treatment at the emergency department and that a physician who is familiar with them will give more consistent care. I also point out that the cost of follow up at the emer-

gency department is more than at a clinic," he says.

Once patients get established in a clinic, they tend to follow up at the clinic, rather than going to the emergency department, Malcolm says.

"The health care system is confusing for people who work in it every day. It's totally bewildering to other people, especially if there is a language barrier. Giving them education and connecting them with community resources keeps them out of the emergency department and keeps them from being readmitted," he says.

Any patient who indicates he or she is self-pay is screened to determine if he or she is eligible for Broward County Tax Fund assistance, a program that provides medical care for patients who do not have any type of health insurance, including Medicaid.

"It can take up to six months to get a patient approved for Medicaid. This makes it difficult to discharge patients in a timely manner. The county programs can issue approval the next day so we can ensure that patients have follow-up visits whether it's with the cancer center, a primary care physician, or a specialist," Malcolm says.

In addition to the financial and medical requirements, to qualify for Medicaid, a patient has to prove residency for five years. The Broward County Tax Fund requires the same financial information but proof of only 30 days residency in Broward County for people to qualify for the Star Card assistance program, he says.

"For people who have immigrated and lived here less than five years or who are undocumented, the Star Card would be the primary option," he says.

The program covers people whose income is up to 300% of the poverty level. Patients pay copays based on their income level.

The benefits include assistance with medications and outpatient, inpatient, and acute rehabilitation services and provides home health through a partnership with a home infusion and home health care agency.

"It's essentially set up like an HMO once they qualify," he says.

People are ineligible for Medicaid if they have savings or other assets, he adds.

"In addition, people have to have medical issues before they can apply for Medicaid. The Star Card fills that gap. When I'm meeting with families, I encourage them to apply for the Star Card and get care at the clinics before they get so sick they have to be hospitalized," he says.

If people are undocumented, they can apply for tax fund assistance but not Medicaid.

"When a patient is in the hospital, I try to talk to the whole family. I tell them that I'm not interested in their immigration status, I just want to get them resources," he says.

Malcolm reports varying degrees of success in trying to help undocumented workers. Many times people say they don't remember their address or how long they've lived in the area for fear that they will be turned into the Immigration and Naturalization Service.

With the exception of people who have both criminal and medical issues and patients with tuberculosis or other public health risks, hospital staff do not notify the authorities of a patient's immigration status.

In the past year, there's been a huge increase in self-pay patients who previously had insurance, Malcolm says.

"People who were doing OK a year ago have lost their jobs and they are scrambling to find health care for their families. And, there are a lot more people who are just one paycheck away from being homeless," he says. ■

What do you do if you don't have data?

You may not have "knock-your-socks-off" data to show that you saved your company thousands of dollars in health care costs because of a wellness program or other initiative. But there are still ways you can demonstrate success and, possibly, save the program or your job in the process.

"Look for things to measure that can bridge the gap if you don't have hardcore data showing ROI [return on investment]. You can still show that there are positive things being provided," says **Don R. Powell**, PhD, president and CEO of the American Institute for Preventive Medicine, a wellness program provider based in Farmington Hills, MI. Some examples:

- Give participation numbers.

"Clearly, the more participation you get for the activities that you provide, the more value is perceived," says Powell. Record the number of people who attended a lunch and learn or how many employees took a brochure at an occupational health "stop by" table.

- Prove that employees are happy with what you are doing.

Give employees a questionnaire that asks them to rate a service provided by occupational health as excellent, very good, good, fair, or poor. "You are then able to show the percentage of employees that say the service was excellent," says Powell.

• Come up with small but eye-catching statistics.

Tell your bosses how many extra steps employees walked this week as a result of an occupational health program, suggests Powell.

• List the "no cost" things you did.

Report on initiatives that the company spent absolutely nothing on, says Powell. "For instance, people will lose weight by putting a scale in a key company location with the diet-plan-of-the-week above it.

"It gets people thinking about weight loss so they can weigh themselves privately," he says. "Or, set up a stress reduction room so employees have a place to go to listen to restful music, instead of drinking coffee, which is a stimulant." ■

Phone coaching saves $311,755 in health costs

Use this method to compute your own ROI

Demonstrating a program's return on investment (ROI) is more important than ever.

"To sell a program, you need to talk about more than just health outcomes. Business people are also looking for an economic calculation for how it might impact their bottom line," says **Ron Goetzel**, PhD, research professor of health policy and management at Emory University's Rollins School of Public Health and vice president for consulting and applied research at Thomson Reuters.

Researchers followed 890 employees enrolled for 12 months in a telephone-coaching program for obesity management, and measured 11 key health risk variables including nutrition, fitness, current smoking, former smoking, stress, cholesterol, blood pressure, alcohol abuse, depression, glucose, and body weight.[1] At the end of one year, the study found statistically significant reductions in seven health risk factors, including a 21.3% decrease in poor eating habits and 15.1% reduction in poor physical activity. The program saved $311,755, mostly from reduced health care spending costs and improved productivity.

Claims-based ROI studies typically require time and financial resources or skills that are not available or not justified, based on the scale of the intervention, says **Kristin M. Baker**, MPH, the study's lead author. "Thus, an evidence-based ROI model, such as the one presented in this paper, is an ideal tool for occupational health professionals to use to determine prospective or retrospective ROI in an efficient manner," she says.

Come up with a good estimate

You can use a similar method to establish a potential ROI for a risk reduction program in your workplace. "If you are able to determine what the actual parameters are, then you can plug in that data along with demographic population to come up with an estimate of cost savings. You can then subtract the investment cost to predict the ROI," says Goetzel, one of the study's authors.

If you don't have that information, though, Goetzel says you can make a guess and come up with a good estimate. "Let's say 30% of the population is obese, and you think the program will be able to reduce obesity rates by one percentage point a year. So you would go from 30% obese to 25% obese in five years. You can plug that into the model, along with demographic information, age, gender, and medical costs. It will then predict how much savings you can expect over that five-year period."

The model used by the researchers can do this for 11 risk factors. "This is not easy to do. The foundation for our model is research we did over the last 10 or so years, using a large database that connects risk factors, demographics, and expenditures." Goetzel says.

Even if you don't have access to this type of detailed data, you can begin with studies that link certain risk factors to higher costs. Show how much more it costs to have a stressed or obese employee, for example.[2] "You need that basic information to do this kind of calculation," Goetzel says. "But you can do that kind of estimate on your own. Then, refer to research that shows you are able to change risk profile in the workplace.[3] And if you change risk, then you save money."

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Use this formula for productivity savings

Researchers calculated the productivity benefits for 890 employees enrolled in a telephone coaching obesity management program, using these assumptions based on previous research:[1]

- If a person loses significant weight and also reduces another risk factor, 40 hours of productivity are gained annually due to reduced presenteeism.
- An additional 20 hours are gained for those who lose significant weight and reduce a third risk factor.
- An additional 20 hours are gained for those who lose significant weight and reduce a fourth risk factor.
- An additional 10 hours are gained for those who lose significant weight and reduce a fifth risk factor.
- Thus, the maximum productivity gain from losing weight and modifying another health risk factor is 90 hours. Annual productivity gain was monetized by multiplying total hours of productivity gained in the year by the participant's average hourly wage.

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Get your fragrance-free workplace off the ground

Attitudes of resistant employees will change

More than half of states have laws requiring 100% smoke-free workplaces, but hardly any workplaces are fragrance free. This is getting increasing attention, however, with growing evidence of the serious health risks posed by synthetic fragrances to workers.[1]

Asthma and migraine headaches are both associated with exposure to fragrances and both are leading causes of lost work time, according to **Evelyn I. Bain**, MEd, RN, COHN-S, FAAOHN, associate director and coordinator of the Massachusetts Nurses Association's Health and Safety Division. "Occupational health nurses have a great opportunity to address the issue of fragrance-free workplaces through their wellness program activities," says Bain.

"I think many occupational health nurses have not been confronted with the concern of fragrance-free workplaces, and thus have not had an opportunity to research the question," says Bain. "There is often conflict between employees on the subject if it does arise."

Employees may be resistant at first, but this changes when they realize the health risks. "It does not happen overnight, but the change in attitude over time is really amazing," Bain says. "Most people appreciate the fact that they can now breathe cleaner air and that they are not experiencing headaches, coughing, and wheezing at work."

To implement a fragrance-free workplace, do these three things:

1. Start with science.

The science of fragrances is an excellent place to begin, says Bain. Educate employees that fragrances are mainly comprised of volatile organic compounds (VOCs), which are associated with a multitude of adverse health effects.

Often, explaining the link between exposure to fragrance and symptoms of headache, sneezing, coughing, and wheezing makes many more people aware that they are in fact experiencing these symptoms in the presence of fragrance, says Bain.

2. Go a step further than employee use of fragrance.

Be sure that chemicals used in environmental cleaning and disinfection, as well as in other processes, are fragrance-free with low or no VOCs as well, says Bain. She recommends using the Material Safety Data Sheets that are required to be available on all chemicals used in the facility to learn what symptoms are caused by the chemicals in cleaners and disinfectants.

3. Connect costs with fragrance in the workplace.

If you link absenteeism and medical expenses to fragrance, the issue becomes "one of logic rather than emotion," says Bain. "Look at your

asthma and migraine headache-related absenteeism. See if you can tease it out from personal health insurance claims," she suggests. "Both of these conditions are quite closely related to exposure to fragrance. Use that information, or simply the association, as you bring fragrance-free workplace proposals to your managers."

Reference

1. Steinemann AC. Fragranced consumer products and undisclosed ingredients. *Environ Impact Assess Rev* 2008. Doi: 10.1016/j.eiar.2008.05.002. ■

Yes, worksite weight loss programs do work

But results might be a 'best case scenario'

If anyone questions whether your company's workplace weight loss programs are really getting workers to lose pounds, you have a ready answer in light of a new review of studies.[1]

Researchers looked at 11 studies published since 1994 on programs to improve diet and physical activity, most involving education and counseling. They found that participants lost an average of 2.2 pounds to almost 14 pounds, while non-participants ranged from a loss of 1.5 pounds to a gain of 1.1 pounds. Programs involving face-to-face contact more than once a month were more effective.

The findings show that these programs work modestly in the short term for those who choose to participate, says **Michael Benedict**, MD, one of the study's authors, and an assistant professor in the Department of Internal Medicine at University of Cincinnati (OH). However, Benedict acknowledges that the programs that were looked at might be a "best case scenario," because subjects were mainly volunteers and highly motivated. "I would anticipate less success if trying to recruit a broader group of obese employees," he says.

The research doesn't give any information on weight maintenance or return on investment for employers. "There is also not much to guide us on how to optimally set up the program, although we believe frequent contact with employees — more than once a month — may be important," says Benedict.

Reference

1. Arterburn D, Benedict MA. Worksite-based weight loss programs: A systematic review of recent literature. *Amer J Health Promot* 2008; 22:408-416. ■

Evaluate this before an injured worker returns

Do a job-specific fitness for duty evaluation

Even if a physician releases an employee to return to work, that employee might still be impaired and at risk for further injury. This risk is because the physician may not realize the job-specific functionality that is needed, warns **Howard M. Sandler**, MD, president of Sandler Occupational Medicine Associates in Melville, NY.

"The person being released to work is fine except for one little thing. If that person is prematurely released and injures themselves, those physicians are at risk for wrongful placement," he says. "There have been a number of successful litigation suits for inappropriate, too early return to work."

Sandler points to a Department of Labor provision that says once the employee's personal physician releases the individual to come to work from the Family and Medical Leave Act (FMLA), you have to put them back to work. "The problem is that few physicians understand what types of abilities are necessary to perform the job or the degree of impairment that is restricting for performance of job functions," says Sandler.

If the physician isn't able to correctly judge whether the worker meets the requirements to do the job without increased risk, there is a danger of the worker coming back and re-injuring him or herself. "They may let somebody come back just because they are running out of FMLA," says Sandler. "Our advice is pay them, but don't put them back to work until you have your own occupational physician perform a true occupational job-specific fitness-for-duty evaluation."

Without this information, you're at risk for making a "bad call," says Sandler. "The bottom line is not to keep people out of work, but to make sure they are off the right time and put back into the right job, according to what their current medical capabilities are," he says.

To avoid a premature or uninformed release to return to work, take this precaution, advises **John**

W. Robinson IV, a shareholder in the litigation department in the Tampa, FL, office of Fowler White Boggs Banker: Provide the medical professional with a detailed job description covering physical demands, emergency duties, hours, and responsibilities.

"Written job descriptions are a start," he says. "Some employers even videotape the demands of the necessary job tasks to share with applicants and medical professionals."

If the employee is re-injured or suffers new injuries after being released to work prematurely, he or she will likely recover workers' compensation benefits, adds Robinson. "Release to work limitations are not an exact science. Some employees perform better than others," says Robinson.

If you suspect a problem, Robinson recommends doing these things:

- Obtain a second opinion on the employee's release to return to work and ability to perform essential job duties.
- Ask the returning employee to demonstrate an ability to perform essential job duties, such as emergency functions.
- Allow employees to return on an experimental or conditional basis for a set time, with evaluation of performance afterward. ■

Diet counseling gets only modest gains

Diet counseling is a part of many employee wellness programs, but a recent review of 38 studies shows this counseling results in only modest improvements in risk factors such as high cholesterol and blood pressure.[1]

Adults who received advice on their diets increased consumption of fruits and vegetables by 1.25 servings, increased fiber intake, and decreased total dietary fats.

"Occupational health professionals know they have a challenge when it comes to changing dietary habits," says **Eric Brunner**, Ph.D., the study's author, and a researcher in the Department of Epidemiology and Public Health at the University College London Medical School.

Individuals at higher risk, such as those with high blood pressure or cholesterol, responded better than those with "average" levels of risk. Also, when more than three personal contacts were made, results were better. The review suggests that "healthy" adults — free of a disease label but not necessarily at low risk — are not strongly motivated to respond to dietary advice.

"The work context is therefore a key factor that can influence dietary habits," says Brunner. "Vending machines, ads, and so on, are equally if not more important than the counseling program."

Reference

1. Brunner EJ, Rees K, Ward K, et al. Dietary advice for reducing cardiovascular risk. Cochrane Database of Systematic Reviews, 2007. DOI: 10.1002/14651858.CD002128.pub3. ■

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COMING IN FUTURE MONTHS

- Ways to provide care to the underserved
- Bringing case management into patients' homes
- Tips on training and motivating your staff
- Integrating behavioral health into your case management program

CE questions

1. How often does the Regence disease/case management program set up campaigns to focus on members with care gaps?
   A. monthly
   B. quarterly
   C. yearly
   D. every other year

2. If preventive care is not possible, **Gavin Malcolm,** LCSW, of North Broward Center, encourages patients to go to an urgent care center.
   A. True
   B. False

3. Which is true regarding the health risk of exposure to fragrance?
   A. Overall, there is very little evidence linking fragrances to adverse health effects.
   B. Migraine headaches aren't linked to fragrance exposure.
   C. Employees may experience headaches, coughing, and wheezing as a result of fragrance exposure.
   D. Absenteeism cannot be connected with fragrance exposure.

4. Which was a finding of a review of 38 studies looking at the impact of diet counseling on risk factors?
   A. Across the board, diet counseling resulted in very significant improvements for cholesterol and blood pressure.
   B. Adults who received advice on their diets actually decreased their intake of fiber, fruits, and vegetables.
   C. Individuals with average risk levels got better results than those with higher risk levels.
   D. Participants had better results when more than three personal contacts were made.

Answers: 1. B; 2. A; 3. C; 4. D.

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CE objectives

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

1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how 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 **June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

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

Salaries are up, but so is the workload

Case managers have more responsibility than ever

Case managers made more money last year than ever before, but they also worked longer hours, according to the results of the 2008 *Case Management Advisor* Salary Survey.

The 2008 Salary Survey was mailed to readers of *Case Management Advisor* in the June 2008 issue.

A little more than half of the respondents (53%) were case management supervisors or directors, and 35% were case managers. The rest held other positions.

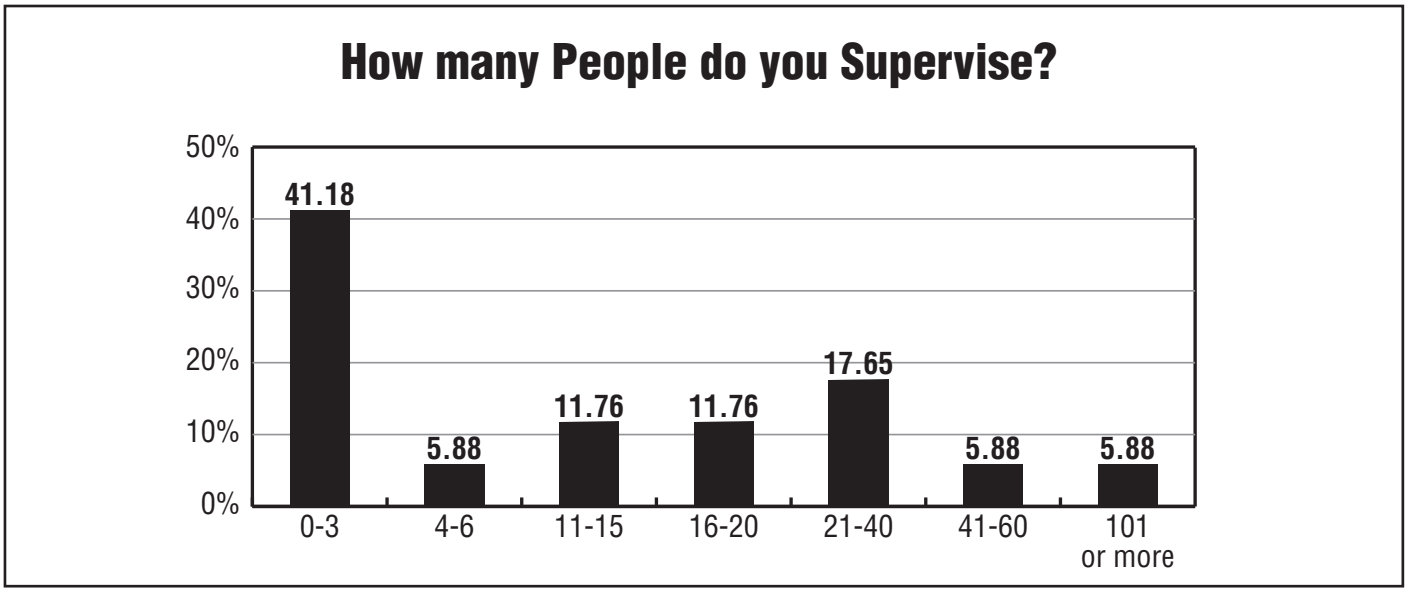
Raises across the board

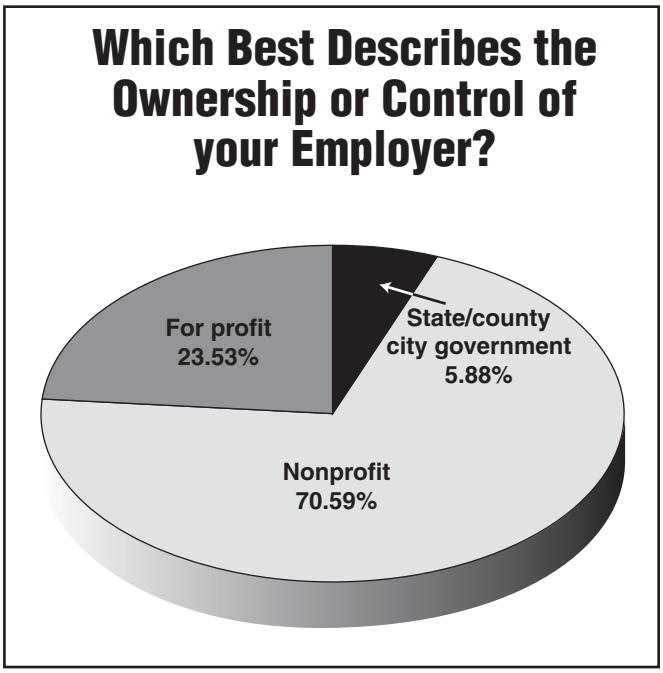
All of the respondents reported getting a salary increase in last year, with the majority (59%) reporting increases of 1% to 3%. More than half (65%) reported salaries of $70,000 or more, with 12% receiving $100,000 or more in annual pay.

More hours

At the same time, respondents to the survey report putting in long hours. The majority of respondents to the survey (69%) report working more than 40 hours a week, with more than 25% reporting working 51 hours or more.

Long hours and more responsibilites than ever before are prompting case managers in every setting, to look at other options, says **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president and





founder of Mullahy & Associates, a case management training and consulting company.

"Case managers are being asked to do more and more in every practice setting and they can't manage everything. Because they're getting burned out at their jobs, they're looking at jobs in the pharmaceutical industry, withthe media, and with software development companies. There are more opportunities for experienced nurses than ever before," Mullahy says.

Case managers once worked Monday through Friday from 9 a.m. to 5 p.m., Mullahy points out.

Round-the-clock' coverage

"Health care is 24 hours a day and the need for 'round-the-clock' coverage has extended to case managers, whether they're in a hospital setting, conducting health coaching on the telephone, or working on a health plan's 24-hour nurse triage line," she says.

At the same time that responsibilities are increasing, staffing in case management departments appear to be on the rise. Almost 71% of the respondents reported an increase in staff in their department or company this year. None reported a decrease.

In last year's Salary Survey, only a third of respondents reported an increase in staff, with 58% reporting no change and 8% reporting a decrease in staff.

Increasing case loads problematic

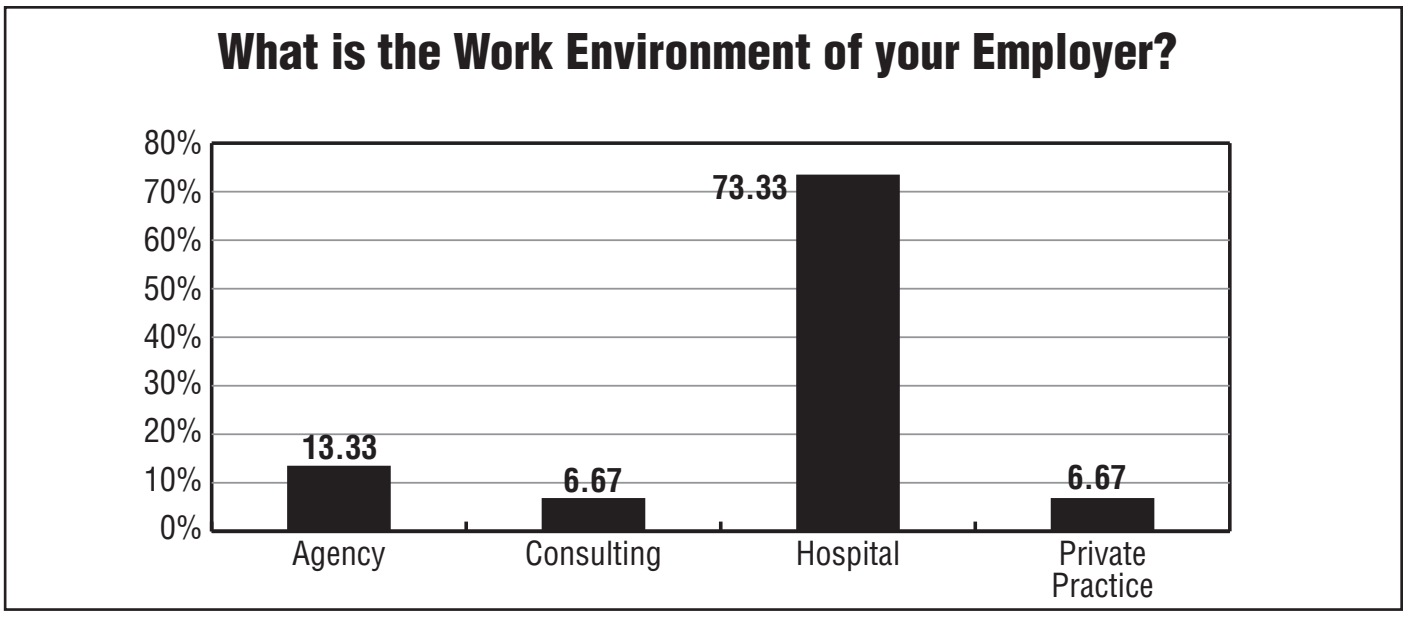
However, increasing caseloads continue to be problematic, Mullahy adds.

"Too many organizations are attempting to streamline operations and don't see that case management is a complex matter and that in order to get the best results, case managers need to have manageable caseloads," she says.

Patients who benefit from case management have complex clinical, financial, and psycho-social issues and need to be managed on an individual basis, which can be time-consuming, Mullahy points out.

This sometimes places case managers in an adversarial role and increases dissatisfaction with their jobs, she says.

"Nurses want to feel good about what they do. In many organizations, that may not be the case because the administration doesn't understand



the role of case managers. No matter what the practice setting, case managers are faced with conflicts when it comes to trying to meet the needs of their employer and do the best thing for the patient," she adds.

Retaining CMs

In order to retain experienced case managers, organizations need to recognize the value that they bring to the table, Mullahy says.

At Hudson Health Plan in Tarrytown, NY, case managers are made to feel they're part of the team and that they can ask for assistance when they feel overwhelmed, says **Margaret Leonard**, MS, RN-B, C, FNP, senior vice president for clinical services.

The department has a daily "stand-up" meeting during which the staff members have an opportunity to talk about what they're working on that day and ask for or offer help as needed.

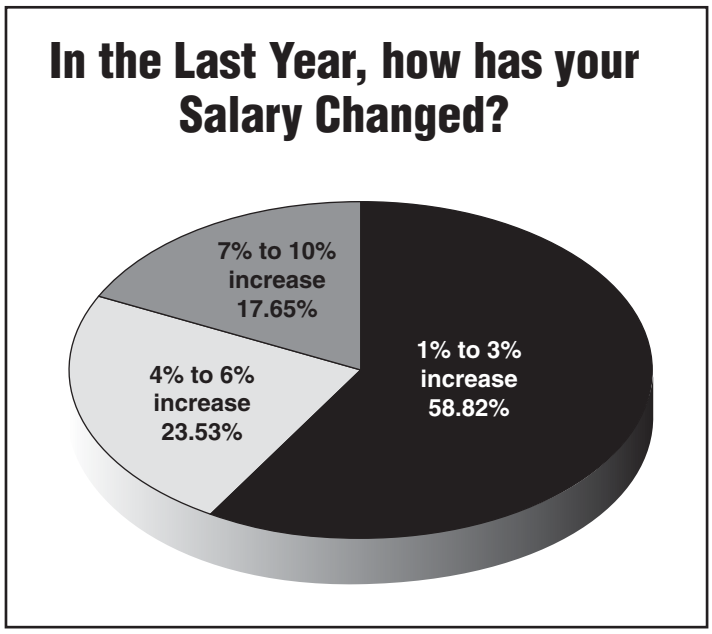
Managers must set priorities

"Managers have to be realistic. If you are down staff—someone is absent or you have a vacancy in your department—you can't expect reports to be done immediately. You can't ask people to do more with less. You have to set priorities," she says.

The case managers and the supporting staff are all cross-trained so they can pitch in and work on any problem or project, she adds.

Hudson has been able to recruit experienced case managers and to retain them over the years, Leonard says.

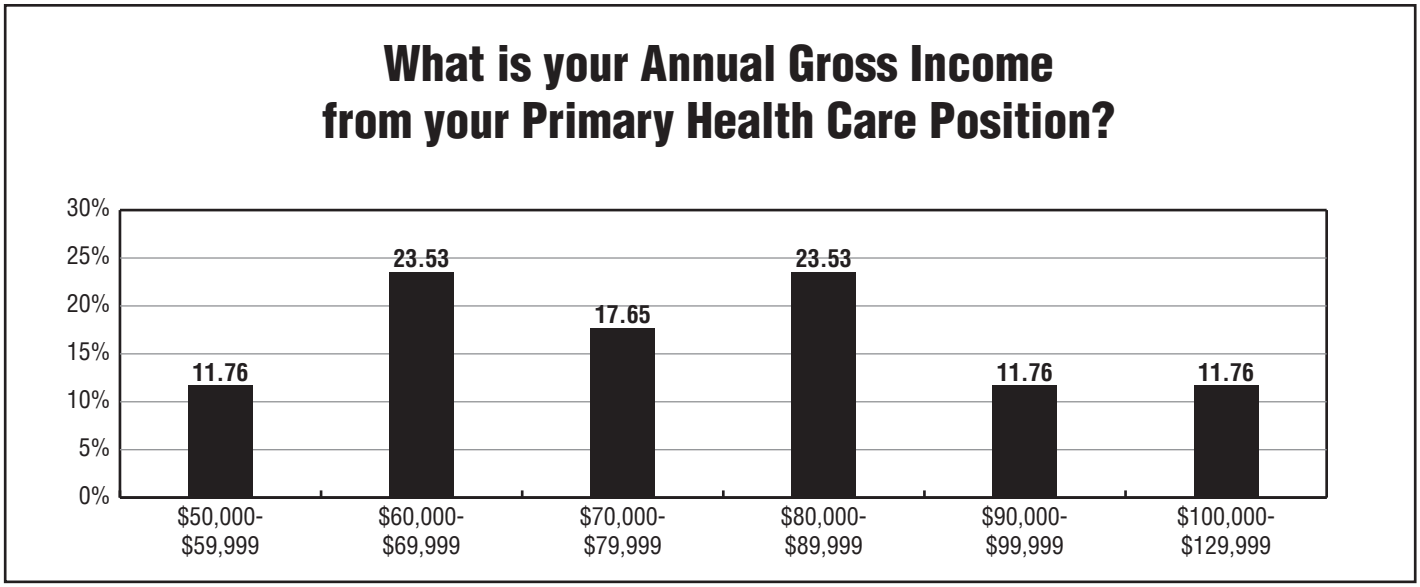
"We've been lucky. We have had little turnover, but when people retire, it's tough to fill their position," Leonard says.



Case managers at Hudson Health Plan are required to sit for case management certification within a certain period of time if they aren't already certified. The insurer pays for the certification review course and gives case managers a substantial increase in salary when they achieve certification, Leonard says.

Case managers tend to be among the most experienced of nurses. More than 93% of respondents to the *Case Management Advisor* survey have worked in health care for more than 16 years or longer, and 67% report working 25 or more years in the health care field.

More than half (53%) have 10 years or more experience in case management.



That experience and the skills that nurses develop at the bedside are necessary for them to be effective case managers, Leonard says.

For instance, telephonic case managers who have worked at the bedside have the experience to recognize when a client's breathing is labored and urge the client to see a doctor, she points out.

"Nothing compares with the frontline duty of being a bedside nurse to get experience. If you haven't been a nurse in a medical-surgical hospital, you can't understand the challenges of admitting a patient, getting data, finding time to complete the assessment, knowing medications, and everything involved in discharging patients or transferring them from one floor or setting to the other," she adds.

But nursing schools are turning out fewer nurses, not because of lack of interest in nursing as a career but because of a shortage of experienced faculty members, Mullahy points out.

"To teach in a university setting requires a master's degree. Nurses with advanced degrees are in high demand in the hospital setting and other fields, all of which pay more than nursing schools can," Mullahy says.

CMs aging

The aging of case managers is likely to make recruiting more difficult in the future, says **Toni Cesta**, RN, PhD, FAAN, vice president, patient flow optimization for the North Shore-Long Island Jewish Health System and health care consultant and partner in Case Management Concepts LLC.

"The pool of case managers is getting older without younger, experienced nurses coming along to take their place. This is going to be a bigger challenge than the nursing shortage in future years," she adds.

About 69% of respondents to the *Case Management Advisor* Salary Survey are over age 50, while 13% report being 61 years or older. Only about 6% report being age 40 or younger. ■

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