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IN THIS ISSUE

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Hospitalist case managers save money, bed days for IPA

On-site staff help ensure timely discharge

After Sharp Community Medical Group placed its own case managers in hospitals to help the hospitalists manage their patients, overall bed days were reduced by 12%, saving the independent practice association (IPA) about $4 million.

"This doesn't mean we didn't continue to provide the same kind of quality care for our patients. The case managers worked with the hospitalists to ensure that care was provided in a timely manner and that the patients have a safe discharge," says **Patti Derouin-Genel**, RN, manager for Sharp Community Medical Group.

Sharp Community Medical Group is one of the largest IPAs in California, with more than 400 physicians on the panel and 155,000 commercial and senior members. Three years ago, the physician group contracted with hospitalists to provide in-house case management at hospitals in the Sharp health care system as part of its efforts to better manage patients through the continuum of care, Derouin-Genel says.

"Once a patient is admitted to the hospital, the medical group is dependent on the services of the hospital staff to get the patients discharged efficiently and effectively. Our nurse case managers partner with the hospitalists to manage the care of our patients and move them through the continuum quickly and safely," she says.

Most of the savings were generated by reducing bed days by moving patients to the right level of care, she adds.

While the acute hospital days went down, the skilled nursing facility days increased, but savings were generated by the lower cost for the lower level of care.

"If patients are really sick, they need to be in the hospital, but when they are able to move to another level of care, it's better for them," she adds.

Derouin-Genel was brought on board to help hire and train the staff to support the hospitalists.

In addition to the nurses who team with the hospitalists to focus on the clinical aspects of care, the medical group hired non-clinical staff, called clinical resource coordinators, to handle all the non-clinical issues, such as ordering durable medical equipment and bed placement in post-acute facilities.

The hospitalists, the hospitalist case managers, and the clinical resource coordinators work as a team in each hospital.

Derouin-Genel interviewed more than 100 people for the hospitalist case management and clinical resource coordinator positions.

"The hospital setting is dynamic and fast-paced. It's a complex job, and it takes a special person to fill it," she says.

The program was a collaborative effort of the physicians in the Sharp Medical Group and the hospitalists, Derouin-Genel says.

"When we initiated the program, we visited all of the facilities to outline the details. We stated that we were willing to bring staff nurses into the facilities to help them manage their patients so they could focus on non-managed-care patients and those who are not insured," she says.

The goal is to provide the right care in the right place at the right time and by the right physician, she says.

The hospitalists and hospital's case managers like having someone to help them manage the care of their patients and help plan the discharge needs, adds **Karla Ascencio**, RN, director of health services for Sharp Community Medical Group

"For instance, hospital case managers are not familiar with the specific contracts the IPA has with post-acute discharge providers. Having our case managers on hand helps them save a lot of time they otherwise would spend looking for details about the patient's benefits," Ascencio says.

The hospitalist case managers follow all of the patients who are part of the IPA and are responsible for utilization review, discharge planning, and ensuring that patients continue to meet criteria for the inpatient stay.

"We do not separate utilization review and case management. Our nurses need to understand everything that is going on with the patient so they can make very astute decisions," Derouin-Genel says.

The case managers round with the hospitalists each morning, review the charts, and discuss the projected discharge plan.

"The physicians and the nurses work as a team, and it is beneficial to everyone. We collaborate closely with the hospitalists, the primary care physicians, the family, and the patient to ensure that patients have a safe discharge and avoid readmission," Ascencio says.

The physician group practice has developed sets of expectations for the case managers to follow in order to provide continuity of care, Derouin-Genel says.

For instance, the case managers educate the patients and families about the inpatient expectations, including the anticipated discharge date, on Day 1.

"Our job is to help the patients and family

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Editorial Questions

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members understand that we are here to work with them to ensure that the patient is at the appropriate level of care. We begin the discussions early on to prepare them for discharge to the next level of care, whether it's home or a post-acute facility," she says.

The hospitalist case managers work at the hospital and come to the office about once a month for staff meetings.

The number of hospitalist case managers on site at each hospital depends on the size of the facility.

For instance, Sharp Grossmont has 481 licensed beds and is staffed by four hospitalist case managers and two clinical resource coordinators as well as a weekend case management staff.

The case managers are assigned by floor and handle both the commercial patients and the senior population. The case managers typically carry a caseload of 18 to 22 patients at a time.

"We could manage the utilization review with higher caseloads, but we want to do more than that. By keeping the census small, the case managers can spend a lot of time working with the patients and family to get them ready for discharge and educate them on what they need to do after discharge to avoid rehospitalization," Derouin-Genel says.

The clinical resource coordinators assist the case managers in identifying and carrying out the discharge plan.

They meet with the patients and families and conduct an interview to help the hospitalist case manager determine what the patient's discharge needs will be. For instance, they ask if patients have to climb stairs, if they have had a physical therapy consult, or if they feel comfortable using a walker.

When the hospitalist case manager identifies that a patient needs to go to a skilled nursing facility, the clinical resource coordinator takes clinical information provided by the nurse and uses an electronic post-acute referral system to identify potential facilities. The clinical resource coordinators arrange the transfers to post-acute facilities, order durable medical equipment, and set up home health care.

"This works well because it frees up the nurses to handle the clinical needs of the patient. They are skilled clinicians, and our goal is to allow them to focus on clinical issues," Derouin-Genel says.

The hospitalist case managers and clinical resource coordinators follow the hospital processes and policies so they don't disrupt the hospital's flow.

Even though the health care system has an integrated model, the hospitals have their own processes, Ascencio points out.

For instance, utilization review and discharge planning are separate functions in some of the hospitals, but at Sharp Community Medical Group, the case managers are responsible for both.

"We do make it a point to follow hospital processes, especially around documentation, delivery of the Important Message from Medicare, and timely discharge. We don't want to interfere with what the hospital is doing and we don't want the hospital staff to have to follow behind us and redo what we already have done so it follows their processes and procedures," Ascencio says.

Sharp Community Medical Group uses hospital data to track variances and determine when there are delays in the process, then comes up with process improvement measures.

If the hospitalist nurses encounter glitches that may delay the discharge or disagree with a specialist, they can call on the medical practice medical director or associate medical directors for help.

The medical group team holds an operations meeting monthly with the hospital administration to discuss any issues that come up.

"Communication between the medical group and the hospital staff has been a key to our success. We've spent a lot of time building collaborative relationships. They're all striving for the same thing we are — a safe and successful discharge," Derouin-Genel says.

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Medical group CMs coordinate care

Patients to get care they need to avoid readmissions

At Sharp Community Medical Group, case managers work in a variety of settings to make sure that patients are getting the care they need in a timely manner and to ensure continuity of care as patients move through the continuum.

The San Diego-based IPA has in-house case managers who provide post-acute and complex case management as well as case managers who work with the hospitalists in local hospitals.

The physician group's disease case managers provide disease management to patients with diabetes, congestive heart failure, chronic kidney disease, and chronic obstructive pulmonary disease.

"We have case managers throughout the continuum to make sure the patients are getting the care they need to prevent readmissions," says **Karla Ascencio**, RN, director of health services for Sharp Community Medical Group.

John Jenrette, MD, the medical group's chief medical officer and CEO, is a firm believer in case management, says **Patti Derouin-Genel**, RN, manager for Sharp Community Medical Group

"Dr. Jenrette feels that nurses have a vital role in coordinating care. This is a very forward-thinking company regarding the benefits of a strong case management program," says Derouin-Genel.

The physician practice has recently developed a case management program in local skilled nursing facilities. That program is staffed by three nurses and two clinical resource coordinators.

The nurses attend case conferences and conduct telephonic review, following the patients through physical therapy, occupational therapy, and speech therapy. They track the number of days to ensure that the stay meets Medicare requirements and follow the patients through any post-discharge care.

"It's a nice continuum. The patients are followed by the hospitalist team and the ambulatory care managers at Sharp Community Medical Group's offices as well as a skilled nursing team. We provide case management at every level of care," Ascencio says.

If a patient who is part of the Sharp system goes to an out-of-network facility, a case manager travels to the facility and manages the patient's care until he or she is stable enough to be transferred to a Sharp facility.

The case managers in the Sharp Community Medical Group refer patients to each other as needed. For instance, if a patient in the hospital has diabetes and isn't already in Sharp's chronic disease management program, the hospitalist case manager refers them.

The inpatient case managers refer eligible patients to case managers within the medical group who provide post-acute case management, complex catastrophic case management, and disease management.

"We integrate all our case management efforts including the chronic disease management program, the telephonic case managers who follow the patients after discharge, and the hospital-based case managers," Ascencio says.

The medical group's clinical resource coordinators call each patient within 48 hours of discharge to ensure that all their needs have been met. This equals about 650 post-discharge calls a month.

They ask several critical questions, depending on the patient's particular situation. These include: Have you made a follow-up appointment? Did you fill your medication prescription? Did your durable medical equipment arrive?

If the patient has questions about medication or wound care or what appears to be a clinical manifestation, the call is immediately referred to one of Sharp's acute care managers who follows up with the patient and contacts the primary care physician or the home health or equipment agency as needed.

If the patients haven't made an appointment for a follow-up visit, the clinical resource coordinators help them do so.

"Ensuring that patients have a follow-up visit with their primary care providers is vital to our success. Many patients who see their primary care doctor after discharge end up back in the hospital," Ascencio says. ■

'Senior Sensitivity' training helps staff understand

Participants simulate vision and hearing loss

Before they start their job managing the care of senior members, case managers at Senior Care Action Network (SCAN) Health Plan try to sort pills while wearing heavy gloves, strain to understand a speaker whose voice is muffled, and fill out a medical information form while wearing special glasses that simulate vision loss.

It's all a part of the Long Beach, CA-based Medicare Advantage Plan's Senior Sensitivity program to help employees feel, see, and hear what common physical and cognitive changes that occur with aging actually feel like and understand how much loss seniors experience as they age.

The health plan requires the Senior Sensitivity training for all of its employees, including board

members, says **Sherry Stanislaw**, senior vice president at the health plan.

"The training is a good complement to the clinical training of the nurses and social workers because they literally get to be in the shoes of the seniors. It helps our staff understand the challenges that their clients face in their everyday life and in adhering to their treatment plan," says **Lisa Roth**, MS, gerontology, director of independent living power and geriatric health management and monitoring.

For instance, during the training, Roth had to walk around with popcorn in her shoes to experience the pain of neuropathy or arthritis in a senior's feet.

"This class helps our case managers understand the problems that members face so they can work with them on strategies that keep them safe at home and out of the hospital. If the senior's eyesight or hearing is limited, the case managers know how to overcome the barriers," Roth says.

The health plan started its Senior Sensitivity training about five years ago.

"The program is based on experiential learning. We use tools to accelerate aging and help the participants understand how seniors may struggle with everyday activities as well as the challenges they face as they maneuver through the health care system," Stanislaw says.

Tools include vision loss glasses that simulate glaucoma, cataracts, and other eye diseases.

In one exercise, the participants are asked to put on the glasses and a pair of bulky gloves and try to open a pill bottle filled with small candies, and then sort the candies according to color.

"This exercise helps the participants understand how seniors struggle when they have arthritis or have lost dexterity in their hands and at the same time have impaired vision," Stanislaw says.

It's a real "ah-ha" moment for many case managers, who often suggest that members who are on multiple medications fill the compartments in a pill box with their medications for each day of the week, says **Kelly Giardina**, MS, gerontology, manager of geriatric health management and monitoring.

"It was hard to fill the box while we had gloves on. Another challenge was trying to separate pills by color while wearing glasses to simulate vision loss. It helps the case managers consider if they are being realistic to expect seniors to fill their pill box. From our perspective, it's easy to think they could use a pill box, but if they have a deficit, it could prevent them from implementing the plan. Typically, they need to have someone set up the pill box for them," she adds.

The participants have to fill out a standard medical information form, similar to the kind used in physician offices, and fill it out with their left hands (to simulate impairments caused by a stroke) and while wearing the vision-altering glasses.

They must write down what they hear on a tape where the speaker's voice is muffled.

"During the classes, we talk about common hearing loss problems, which are common in the senior population. Many seniors can hear vowels but lose their ability to hear consonants, particularly on the end of words. When we play the tape, the participants are straining to hear and understand, and most of them get most of the words wrong," she says.

The program also deals with psychological losses that occur as people age. The participants have to write down the three most treasured things they have — family members, jobs, etc. The facilitator walks through the room and starts snatching things away from the participants.

"It's amazing how people react when the facilitator takes away the things that are important to them," she says.

A memory loss exercise gives participants a list of items that they have to remember.

"At the same time we are doing these exercises, we also remind participants that you can never stereotype seniors. Not every older adult experiences all these losses. A lot of it is individual," she says.

The trainers give the class tips on how to compensate for the disabilities during their interaction with members.

The case managers at SCAN range in age from the very young to those who are almost seniors themselves. Some have experience working with patients face to face but others have only telephonic case management experience, Roth says.

"Without the experience of a deficit yourself, it's hard to understand what seniors face in the real world and to come up with unique ways to help members be adherent. The classes give them the feel of having a deficit and serve as a good reminder to put ourselves in the situation of the seniors," she adds.

Part of the initial case management assessment is to gather information that helps the case manager understand any challenges the member may face, Roth says.

"We ask about their vision, their hearing, and other functional aspects to assess some of the potential challenges the member has so we don't assume that the member can do things or understand things when they can't," she adds.

The case managers learn to adjust their pace and their volume as they interact with members, Giardina says.

"They stop and confirm that the member understands what they are saying and can repeat it back. It is a matter of adjusting interactions to compensate for whatever deficits the member may have," she says.

The case managers are trained to look for signs of deficits and vary the services they provide based on the different needs of their clients, Roth says.

For instance, if someone is visually impaired, the case managers may send them information in large print or provide an audio resource for the information.

"As a result of the program, the case managers work with the physicians to get the members a large-print copy of the medical questionnaire and send it to the members ahead of time.

"The case managers in our geriatric health management program always work on preparing the members for their doctors visits, helping them gather the information the doctor needs, and empowering them to make their doctor visits successful," she says.

As a backup to help overcome hearing and memory deficits, after the case managers talk to members, they send out a letter recapping what they have gone over during the telephone call, Giardina says.

"We do this because many of our members have trouble hearing and it gives them the information in writing that they can take to their doctors," she adds.

The health plan uses risk stratification software to identify high-risk members based on their diagnoses and prior medical encounters.

When a member is determined to be at risk for hospitalization, the health plan's outreach staff contact them to find out if they are interested in enrolling in the case management program.

The case management program also receives referrals from physicians and from members who learn about the program and want to participate.

The case managers work with the members to help them manage their health care and adhere to the treatment plan. In addition to their extensive assessment, the case managers have information generated from encounter data with the physician medical group and hospitals.

"They have a picture of the patient before they call them. This puts us in a good position to come up with a plan to help the members manage their chronic conditions and live as independently as possible," Roth says.

The case managers use motivational interviewing techniques to determine the members' willingness to make changes and help them set short and long-term goals.

In addition to requiring Senior Sensitivity classes for its staff, the health plan has offered customized training to contracted providers to help them understand the challenges that the senior members face. For instance, during the training, the staff at physician offices spend a lot of time trying to fill out the patient registration form while using equipment that simulates deficits.

In Arizona, the health plan recently partnered with Dependable Medical Transportation Services to train more than seasoned van drivers about the challenges that seniors face.

SCAN has given classes to elementary school children to help them learn to better understand their grandparents.

"We talk to the kids about communicating with their grandparents and teach them techniques like being face to face when they talk so the seniors can hear them and pick up on both visual and audio cues. It's all a matter of understanding the other person's challenges," Stanislaw says.

*(For more information, contact **Lisa Roth**, MS, gerontology, director of independent living power and geriatric health management and monitoring, e-mail: lroth@scanhealthplan.com.)* ■

A small-scale wellness program got big results

Because the average UPS driver walks four and one-half miles a day, you'd think it would be difficult to convince them to come in early for a two-mile warm-up walk, but they do. This is just one example of how the company's Petaluma, CA, facility succeeded in changing the lifestyles of its workers.

Two years ago, the facility's rate for DART (days away from work, restricted work activity, or job transfer) was 10.3 for every 100 full-time employees, 2,000 hours a year. Something had to be done. A group of managers and drivers

"brainstormed," says **Josh Young**, the facility's center manager, who oversees 200 employees.

"We knew we needed to come up with something different to reduce the number of injuries. We asked, 'What can we do as a group that is different than our day-to-day regimen?'" says Young, who sits on the group's safety committee supporting drivers' safety and health initiatives.

The group's three-pronged answer: a walking club, a nutrition program, and yoga classes. At first, only one or two drivers participated, but the number grew steadily, due mainly to word-of-mouth recommendations from co-workers. Injury rates, on the other hand, started to drop. The DART rate is now 4.2 for every 100 full-time employees.

The goal is to make drivers "industrial athletes" who are fit enough to do the heavy manual labor required for the job. To reach this accomplishment, drivers first need to answer the question: "Why should I do this?" says Young. The answer differs for every employee, he says, and might be "so I can play with my kids when I get home" or "so I can lose weight."

"The hardest part is taking that initial step. We showed them the benefits that they can walk away with. Then we went mostly on word of mouth," he says. Outside wellness experts were hired to talk about nutrition, and a yoga teacher held classes in the early mornings. When the classes became too crowded for the space, a group of drivers arranged to meet at the yoga studio before work.

One driver now rides his bike from his house to the gym, then rides the bike to work, and then works his shift. Another driver weighed more than 400 pounds and was counseled on better eating habits, which resulted in significant weight loss. "He is another example of someone who has 'caught the bug,'" says Young. "Another of our drivers [has] quit smoking for six months. We have a lot of inspiring stories." ■

Let employees decide how to be safer and healthier

Workers ID root causes of accidents

Instead of management telling UPS employees how to improve their health and safety, the company's 12,000 frontline employees, who sit on more than 3,000 "comprehensive health and safety process" committees, decide that for themselves.

"UPS drivers move about 16 million packages a day. It's a very physical job. There's no such thing as a virtual package," says **Dan McMackin**, spokesman for UPS. "Everything people order on the Internet has to be delivered by somebody and picked up and carried."

The employees are the ones who investigate accidents to find out the root causes behind what happened. For example, they discovered that most back injuries occurred later in the afternoon when drivers are fatigued and fail to follow the correct lifting procedures.

"Committee members focused their efforts on making drivers aware that safe work methods are crucial, especially as the day wears on," says McMackin.

Each driver who has had an injury, no matter how minor, is given a refresher in the techniques taught in the company's internally developed UPS Safe Work Methods training course.

Beginning in 2008, each committee was required to nominate one person as a wellness champion, who is given wellness materials from corporate headquarters. The wellness champion leads the group with current health topics and points employees in the right direction to access health care resources. "It's a huge investment in time and resources and funds; we have to pay these people an hourly rate while they are doing all this and not getting their productive work done. But it pays back tenfold because you've got healthier, happier people coming to work," says McMackin.

Re-injury rate cut to 6%

Each month, the committees focus on a different topic, such as stretching, heart health, or nutrition, says **Mary Breen**, RN, COHN-S, CCM, corporate occupational health manager of UPS.

Recently, the committees looked at their most frequent injuries, on and off the job. "In the workers' compensation arena, we've narrowed it down to knee, back, and shoulder injuries, and in the disability area, musculoskeletal injuries," says Breen. "So we knew a lot of our injury cost was due to those injuries, and also reinjuries, with the next one being more severe."

A 30-minute education program was developed by corporate occupational health, to teach injured employees how to do the proper job

setup. The company's 22% re-injury rate was cut to 6% after only nine months.

The wellness champion is charged with investigating the root causes of injuries. "But we have reduced our injury frequency over 60% over the last five years, so they have a lot less to investigate," says Breen. "We have seen a 10% reduction in back, knee, and shoulder injuries for our full-time employees in 2008 compared to 2007 with this initiative. We are hoping to see a decrease in the increase of our health care costs."

Successes are shared

Last year, disease management coaches were added to reach out to workers to prevent and treat chronic conditions. "We started off with the four big ones: coronary artery disease, diabetes, asthma, and chronic obstructive pulmonary disorder. People can go in themselves and get a nutrition coach," says Breen.

A quit-smoking program is free for the majority of employees. All employees can also access a companywide employee assistance program with six free therapy visits.

This year, health risk assessment data are being used to identify the number of employees with risk factors. "That is a brand new product this year. You can look at how many are at low, moderate, and high risk, and you can actually put a financial number to that," says Breen.

Successes are shared via the company's best practices health and safety department, which consists of about 60 occupational health nurses nationwide. "They can send in presentations that are put on our internal web site, such as the success they have seen with a stroke program, a walking program, or a blood pressure program," says Breen. ■

Needlestick benchmark can be safety 'snapshot'

Internal comparisons may be most helpful

Suppose needlesticks at one of your health care facilities rose this year compared to last year. That doesn't sound so good. Clearly things are not going in the right direction. But you need more information to understand what's happening. You need a benchmark for your needlesticks.

First, you need to calculate a needlestick rate. If the numbers rose but the procedures or bed count grew even higher, then your rate actually might have gone down.

You also need to dig a little deeper into the dynamic of your sharps safety program. "If you're going to assess how successful your program is, the number of injuries has to be just one component," says **Angela K. Laramie**, MPH, epidemiologist with the Sharps Injury Surveillance Project in the Massachusetts Department of Public Health in Boston. "Evaluate whether your injury reporting has changed in any way or whether frontline employees are getting more involved in device selection.

"If you use injuries as the sole measure of success of a program, then you risk driving reporting underground," Laramie says. "You risk that people aren't going to want to report their injury, and that's counterproductive because we miss the opportunity to provide appropriate care to injured employees and to learn more about those injuries so we can prevent them in the future."

Yet in the quest for injury reduction, rates can be useful, if they're properly evaluated. A comparison with a national database, such as the EPINet network of the International Health Care Worker Safety Center at the University of Virginia in Charlottesville can bolster a case for more resources to tackle sharps safety. Associate Director **Jane Perry**, MA, says, "Oftentimes, hospital administrators will want to know, 'How do we compare to other institutions around the country?'"

Numerator: Number of needlesticks

So how do you calculate your rates? What, exactly, should be in your numerator and denominator?

Clearly, your numerator will be the number of needlesticks, but you might want to look specifically at units such as med-surg, emergency department, or the intensive care unit. Your denominator will vary depending on what you are trying to measure.

Do you want to know who is sustaining the most needlesticks? You'll need to use FTEs to compare occupational groups, such as nurses, phlebotomists, and physicians. How frequently do they occur? In some units, you may be able to use the number of procedures. Which devices or device categories are associated with the most needlesticks? This is a tricky question, but you might be able to obtain purchasing data from

materials management.

Those internal markers will provide information for action. "You should benchmark against your own data and really look at yourself over time," says Laramie. "It's important to take a broad assessment of what's happening hospitalwide, but I think it's more important to take a few devices and really look at where those injuries are occurring."

Public hospitals in Texas and all acute care and chronic care hospitals in Massachusetts are required to report their bloodborne pathogen exposures. These and other national databases collect information per 100 beds. For example, if you had 350 needlesticks in one year and you had an average of 800 occupied beds, your rate would be 350 divided by 800, multiplied by 100, or 44 per 100 occupied beds.

"You can use the national-or state-based data to get a sense of what is going on," says Laramie. But she cautions that you need to compare yourself to similar facilities. EPINet, for example, reports its data for teaching and nonteaching hospitals.

Perry says, "Teaching hospitals always have higher rates because they have more trainees and they're often doing more intensive procedures using more needles."

Different populations, procedures

Different patient populations might mean hospitals perform different types of procedures, so other factors ranging from geography to size may influence needlesticks, Laramie says.

It also is important not to view a national or state benchmark as a goal or best practice. It is just a snapshot of current performance. If your rate is better than the average, that doesn't necessarily mean your rate is "good" or "acceptable." Your goal should be continual improvement.

"I don't want anybody to say in the state of Massachusetts 40% of injuries happened to nurses and at our hospital it was only 30%, so we're doing really well," Laramie says. "I don't like our data to be used as a benchmark. The benchmark assumes an acceptable level or a goal. My data are not a goal. They are a picture of what exists."

After all, the goal is not to do better than most hospitals on needlesticks. The goal, notes Laramie, is zero.

In fact, a low number of needlesticks actually can be a bad thing, if the numbers are low because health care workers are reluctant or uninformed about reporting, she notes. "Get employees involved as much as you can [in sharps safety]," she says. "If you see a low number of injuries, be aware that it could say something about the underreporting in the facility." ■

Are sleepy workers a threat to safety, productivity?

About one-third of 1,000 workers said they had fallen asleep or become very sleepy at work in the previous month, according to a recent National Sleep Foundation survey.[1] Also, about 10% of adults reported not getting enough sleep every day for the previous month, says a recently published study from the Centers for Disease Control & Prevention (CDC).[2] The study also indicated that the percentage of adults who report sleeping six hours or less has increased from 1985 to 2006, across all age groups.

What can occupational health professionals do about this dangerous problem? According to **Lela R. McKnight-Eily**, PhD, the study's lead author and a behavioral scientist in CDC's Division of Adult and Community Health, you can begin by assessing whether workers are sleep-deprived. McKnight-Eily recommends using measures such as the Epworth Sleepiness Scale and Stanford Sleepiness Scale, which are used to measure daytime sleepiness.

"There are numerous health benefits that can be linked to employees improving sleep habits," says McKnight-Eily. Sleep disorders and sleep loss are significantly associated with mental distress, depression, anxiety, obesity, hypertension, diabetes, high cholesterol, and adverse health behaviors such as cigarette smoking, physical inactivity, and heavy drinking, she says.

"Sleep can be incorporated into employee wellness programs," she says. McKnight-Eily recommends:

- Encourage workers to take short naps; avoid caffeine, alcohol, or stimulants several hours before going to sleep; and relax before going to bed.
- Warn employees to be cautious about drowsy driving, as it is a cause of motor-vehicle morbidity and mortality.
- Encourage shift workers to obtain adequate sleep during the time that they are not working.

"Employees who have persistent issues with obtaining adequate sleep, may require an assessment by a health care employee for the presence of a sleep disorder," says McKnight-Eily.

References

1. National Sleep Foundation. 2008 Sleep in America Poll. 2008: Washington, DC.
2. McKnight-Eily LR, Presley-Cantrell LR, Strine TW, et al. Perceived insufficient rest or sleep — Four states, 2006. *MMWR* 2008; 57:200-203. ■

Simple changes can benefit shift workers

Shift workers are at higher risk for injuries, accidents, and absenteeism, but simple work schedule changes can improve the health of these employees, according to a new review of 26 studies of shift workers, including autoworkers, nurses, and chemical plant employees.[1]

Two interventions were shown to have a positive impact: rotating workers through shift changes more quickly — every 3-4 days instead of every seven days — and giving employees more control over their schedules.

Companies are very resistant to addressing the needs of shift workers, according to **Alec J. Davidson**, PhD, an assistant professor with the Neuroscience Institute at Morehouse School of Medicine in Atlanta. "I think that the issue is underappreciated," says Davidson. Animal research from Davidson's lab and others is revealing that, independent of any other factors associated with shift work, altered lighting environments that induce chronic jet-lag, which is similar to rotating shift work, have significant health costs.

"It appears that these schedules tend to increase the risks of a number of pathologies, including cancers, and the risks associated with environmental toxin exposure," he says.

Unfortunately, Davidson says it may be too early to propose changes to specific lifestyles or work schedules just yet, as a better understanding of specific risk factors is needed. Until then, he advises encouraging shift workers to lead otherwise healthy lifestyles including healthy eating and weight management, frequent exercise, avoidance of tobacco or excessive alcohol usage, and getting plenty of sleep.

Reference

1. Bambra C, Petticrew M, Whitehead M, et al. Shifting schedules: the health effects of reorganising shift work. *Amer J Prev Med* 2008: 34:427-434. ■

Employees might be going to India for surgery

Wellpoint is testing a program that allows patients the option of going to India for elective surgery, according to *The New York Times*.[1] There are no out-of-pocket medical costs, and travel is free for the patient and a companion, according to the article

The program is being tested at Serigraph, a printing company in Wisconsin where managers are looking to address increasing health care costs, said **Razia Hashmi**, MD, chief medical officer for national accounts for Anthem Blue Cross and Blue Shield, which is affiliated with Wellpoint.

Hashmi said that the insurer will monitor the project to ensure positive clinical outcomes and patient satisfaction.

The Deloitte Center for Health Solutions, a consulting firm, predicts that by the year 2010, more than 6 million Americans annually will be seeking medical treatment abroad, says the *Times* article, which points to potential cost savings. Knee surgery that costs $70,000 to $80,000 in the United States can be performed in India for $8,000 to $10,000, including follow-up care and rehabilitation, the article quoted Hashmi as saying. Similar savings could be achieved for other procedures including hip replacements and spine surgery, the article says.

If other insurers follow Wellpoint, Hashmi said, U.S. hospitals might feel pressured to be more competitive in their pricing. The program potentially could pull the healthiest and most profitable patients away from a local hospital, said **Howard Berliner**, ScD, professor of health policy and management at State University of New York Downstate Medical Center in Brooklyn.

The program would appeal primarily to people who have traveled abroad, Hashmi predicted in the article. Many employees of Serigraph, which has offices in India, are familiar with the country. Hashimi said the quality of care is comparable in the two countries. All the physicians speak English, the article said. Patients can share their medical records and consult with a surgeon in India before going, Hashimi said.

The pilot program arranges for patients to be picked up at the airport, and it provides special

meals to prevent foodborne illnesses. The program complies with the American Medical Association guidelines on medical tourism and uses hospitals accredited by Joint Commission International.

However, medical tourism would be of limited appeal to Americans with private health insurance, predicted Berliner, who said one terrible outcome would squash excitement about such a program.

Reference

1. Rabin RC. Insurer offers option for surgery in India. The New York Times, Nov. 21, 2008. Accessed at www.nytimes.com/2008/11/21/health/21abroad.html?_r=1&ref=health. ■

Telephone may be effective in weight loss maintenance

Face-to-face and telephone follow-up sessions appear to be more effective in the maintenance of weight loss for women from rural communities compared with weight loss education alone, according to a report in the Nov. 24 *Archives of Internal Medicine*. In addition, telephone counseling appears to be just as effective as face-to-to face counseling for weight loss management.

"Rural counties in the United States have higher rates of obesity, sedentary lifestyle, and associated chronic diseases than nonrural areas, yet treatment of obesity in the rural population has received little research attention," according to the authors. Studies have shown that diet, exercise, and behavior changes can produce significant weight loss and that extended care programs such as clinic-based follow-up sessions can improve weight loss maintenance. "However, in rural communities, distance to health care centers represents a significant barrier to ongoing care," the authors write.

Michael G. Perri, PhD, of the University of Florida, Gainesville, and colleagues conducted a randomized trial involving 234 obese women (ages 50 to 75) who completed a six-month weight loss program in six medically underserved rural communities. The women were randomly assigned to three extended-care programs consisting of 26 biweekly sessions for one year. There were 72 participants who received telephone counseling, 83 who received face-to-face counseling, and 79 who received biweekly newsletters containing weight loss maintenance tips. Estimated program costs were also assessed.

Average weight at the beginning of the study was 96.4 kilograms (212.5 pounds). The average weight lost during the six-month intervention was 10 kilograms (22 pounds). One year after the beginning of the study, "participants in the telephone and face-to-face extended-care programs regained less weight [an average of 1.2 kilograms (2.6 pounds) for each group] than those in the education control group [an average 3.7 kilograms (8.2 pounds)]," the authors write.

"The beneficial effects of extended-care coun-

COMING IN FUTURE MONTHS

- Helping seniors stay safe at home
- Extending wellness programs to the worksite
- Case management for an increasingly diverse population
- Helping patients and families with end-of-life decisions

CE questions

8. After Sharp Community Medical Group placed case managers in hospitals to help the hospitalists manage patients, overall bed days were reduced by how much?
   A. 10%
   B. 12%
   C. 20%
   D. 22%

9. Senior Care Action Network (SCAN) Health Plan requires all employees to undergo "Senior Sensitivity" Training.
   A. True
   B. False

10. Which initiative is part of an approach which resulted in decreased injury rates for UPS drivers?
    A. Only management investigates root causes of injuries.
    B. Employees investigate injuries to find out root causes.
    C. Wellness champions are always senior managers.
    D. Employees serve on health and safety committees, but they are not paid for their time.

11. About one-third of 1,000 workers said they had fallen asleep or become very sleepy at work in the previous month, according to a recent National Sleep Foundation survey
    A. True
    B. False

Answers: 8. B; 9. A; 10. B; 11. A.

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. ■

seling were mediated by greater adherence to behavioral weight management strategies, and cost analyses indicated that telephone counseling was less expensive than face-to-face intervention," the authors note. "Our findings highlight the benefits of extended-care interventions and indicate that telephone counseling represents an effective and cost-efficient approach to the management of obesity in underserved rural settings." ■