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## IN THIS ISSUE



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# Personal contact helps identify hard-to-find members for health plan

*Program coordinates care for the chronically ill*

**Dania Anderson**, LCSW, is something like a detective. As an outreach coordinator for Health Integrated, a targeted population health management company, Anderson visits doctors' offices, hospitals, clinics, group homes, soup kitchens, and other community agencies in her quest to locate health plan Medicaid members receiving Supplemental Security Income (SSI) benefits who could benefit from Health Integrated's care coordination programs.

The members also can benefit from Health Integrated's Synergy Targeted Population Health Management program, a health improvement program for the chronically ill that addresses medical and psychosocial challenges, Anderson says.

"These members are a challenging group to reach. They are a population frequently on the move. Some are homeless. Many of them do not have a regular place to live but do have a cell phone, and if we find them, our Synergy care coaches can keep in touch with them that way," says Anderson, who serves a managed care plan client in New York City.

Health Integrated's Synergy program provides health coaching, education, and support for chronically ill individuals through contracts with health plans.

Outreach coordinators, such as Anderson, work locally to identify community-based programs, develop relationships with physician practices, and help engage members in the Synergy program. They collaborate with Synergy care coaches.

The outreach coordinators work to develop a relationship with the key care providers and work together to see that members get the care they need, Anderson says.

For instance, the outreach coordinators notify homeless shelters when they are trying to reach a certain member.

"Sometimes that person will suddenly show up, and with the help of

the shelter staff, we'll be able to make contact," she says.

Connectivity between all of the people and organizations involved in a member's care is the key to the success of the Synergy program, says **Mike Miniati**, vice president of marketing for Health Integrated.

"We act as a hub to connect people to all the different places that offer them help," he says.

This may be the physician, the member's health plan, community-based organizations, or the members themselves.

"Members may be receiving services from a lot of different places or may not be aware of the resources available to them. We connect the dots," he says.

This part of the Synergy program, called Synergy Connect, has two main components that work together: care coordination and outreach coordination.

The care coordination component ensures that appropriate care is coordinated and delivered by members of the care community and establishes referral pathways to the various programs and resources available. Outreach coordination works primarily with health plans and in the local community on strategies to connect with members who are difficult to find. The goal is to collaborate with the care managers and physician practices to help overcome the members' barriers to care and encourage adherence to their treatment plan.

The outreach coordinators are a key to the success of the Synergy Connect program, Miniati says. **(For information on how the care coaches work with members, see related article on page 40.)**

"In supporting clinically complex individuals, especially among the Medicaid population, one of the biggest challenges is making contact to offer assistance. By working locally, the outreach coordinators can not only reach these individuals but also ensure that they get local assistance for social or personal issues while they receive telephonic support from a Synergy care coach," he says.

A case in point is Anderson's success in facilitating care coordination for seven members traced to a group home who were dealing with physical and mental disabilities.

Often, phone contact alone won't get the member engaged in the program, Anderson points out. For example, group homes may have only a common pay phone for the entire facility.

"In such cases, we will go to the location to work one on one with the people in need of help," she says.

Working with the health plan, Anderson took an in-depth look at the members in the group home and determined that they were high-risk, complicated cases.

"As a result, the health plan placed a nurse practitioner in the group home to ensure that the members get the care they need, and she refers any cases to me to be connected to a care coach," Anderson says.

The nurse practitioner has added medical information that helps the care coaches stay aware of the members' needs and conditions.

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## Editorial Questions

Questions or comments? Call **Mary Booth Thomas** at (770) 934-1440.

"In addition, part of the outreach coordination process has been to create a system where the staff at the group home remind members when the care coach is scheduled to call so they can be near the telephone. This can make a big difference in continuity and success for the member," she says.

The health coaching supports the group home staff by motivating the members to remember to take their medication, wear the appropriate clothing, and engage in activities of daily living.

"Staff under too much stress might misjudge a situation, sending someone to the emergency room, for example, when that is not the best response in the circumstance. Our goal is to avoid unnecessary hospital stays with the high-risk cases," she says.

The outreach coordinators live in the area in which they work and are familiar with the services that are available.

"They have extensive knowledge of the community and can help identify and solve the social problems that members may face," Miniati says.

Working with the health plan, Anderson maintains a list of members and their primary care physicians. She meets with the physicians who provide care for the highest number of high-risk members and explains how the program benefits the member and the provider.

"We are hoping to make things a little easier for the providers. The care coach can help members prepare for their appointments and encourage them to follow their treatment plan. This kind of support reduces follow-up phone calls," she says.

Primary care physicians rarely have the time to deal with patients' psycho-social issues and welcome the assistance from the outreach coordinator and the Synergy program in general, Miniati says.

"Having the outreach coordinator meet face to face with the staff in the physician offices is part of what has proved to be a very successful rapport-building approach. We provide education to illustrate that we are there to support their plan of treatment and to assist their patients toward better care management," he says.

Once the outreach coordinators create a relationship with the physician office staff, they ask for help in updating the phone numbers and addresses they have for members and enlist their aid in contacting the members, Anderson adds.

Anderson gives providers stickers for the patients' charts to remind staff that she is trying to reach a particular member. In addition, Health Integrated has created a prescription pad that the physicians can use to refer patients to the Synergy program. The pad has information about the program and a number that the members can call.

Anderson looks at the patient files to determine when the member she is trying to reach has his or her next appointment.

"One of the main issues with the Medicaid population is that they don't keep appointments. They have a tendency to walk in," she says.

Depending on her schedule, Anderson either goes to the clinic to meet patients herself or calls the office on the day of the visit and asks staff to give them material about the program. She leaves materials such as brochures and motivational cards for the staff to give to members and asks that it be placed in their charts.

Anderson calls members an hour or so after she estimates patients have gotten home from an appointment and tells them about the program.

When Anderson gets in touch with the members, she explains the Synergy program and how it works with their health benefits.

"We want them to know who we are and that we're calling from a program that is free through their health plan. I tell them how health coaching works. I explain that a care coach is someone who is there to listen to them and help them manage their health," she says.

When Anderson mentions that a care coach can help them deal with the stressors they encounter when they are trying to navigate the health care system, it often piques members' interest.

"They start telling me the ways they have been stressed out by the plan or their physician or their medication or the problems they have getting authorization for treatment. We let them know that we understand that stress is increased when you feel you aren't being heard and that's what a coach is for," she says.

The next step, she hopes, is to connect the member to his or her personal care coach through warm transfer or, if necessary, by scheduling an appointment.

"Sometimes I might be meeting them in the provider's office and don't have cell phone access. If that happens or if the member can't speak to a coach at the time we talk, I set them up with the next available appointment," she says.

Some members want to receive information only in the mail. In those cases, Anderson sends the information and calls them back to make sure

they received the material and find out if they are ready to work with a health coach.

"We stay in touch with the members and try to engage them whenever they are ready," she says.

The relationship between the outreach coordinator and the physician offices is especially valuable when the Synergy care coach has been working with a member telephonically and has identified a particular need or challenge, Miniati says.

"The outreach coordinator is right there and can work face to face with the doctor's office to solve the problem," he says.

"Most of the time, it's the little issues, such as that providers don't understand the health plan's protocol," Anderson adds.

For instance, one member was feeling stressed because he hadn't gotten authorization for physical therapy treatment because the specialist office didn't realize that the primary care physician had to request the authorization.

Anderson stepped in and got the authorization number to clear the way for treatment.

The care coaches work closely with the Synergy outreach coordinators to meet the members' needs, even when they aren't directly involved with health care.

In one instance, a health coach was working with a Brooklyn woman who speaks French Creole and who needed to connect with people who speak her language.

She had financial constraints that prevented her from traveling around the city.

Anderson was able to connect her with a program that was within walking distance of her home and that had staff who spoke her French dialect.

"Any kind of stress can exacerbate a member's chronic condition and make it difficult for him to adhere to the treatment plan. We try to relieve the stresses in their lives so they can concentrate on improving their health. Our goal is also to provide knowledge and information to empower the member to make changes," she says.

Anderson can call on the company's multi-lingual health coaches when she needs help communicating with a member who speaks little English.

"When a member speaks only Spanish, we send them information in Spanish and use Spanish-speaking coaches for the engagement process," Anderson says. ■

# Collaborative effort helps chronically ill

*Program targets members with psycho-social issues*

An approach that incorporates its telephonic integrated health coaching services with health plan case management and other health management programs, community-based resources, and physician practices has paid off for Health Integrated.

The Tampa, FL-based targeted population health management company contracts with health plans to help manage the care of chronically ill members who also struggle with psychological issues and face social challenges.

"Left alone, these psychosocial challenges can undermine the best efforts of physicians, family members, and even patients in managing chronic diseases. We work with the 10% to 15% of a health plan's chronically ill population that represents as much as 50% of the cost of care," says **Mike Miniati**, vice president for marketing.

Health Integrated's Synergy Targeted Population Health Management program provides health coaching, education, and support for chronically ill individuals through contracts with health plans. Care coaches, most of whom have a behavioral health background, work telephonically with members to help them manage their chronic illnesses and psychosocial barriers.

They collaborate with the company's community-based outreach coordinators if the member needs transportation to the doctor's office, help with housing problems, or other community resources.

Having outreach coordinators in the community helps Health Integrated's care coaches connect with hard-to-reach members. **(For a look at how the outreach coordinator program works, see related article on page 37.)**

"We initiate outreach telephone calls and mailers to engage the members so the care coaches can work with them over the phone on preventive care. Then we work together as a team with the coaches and physician practices to find a solution to problems and to empower these members to work on improving their health," says **Dania Anderson**, LCSW, Health Integrated outreach coordinator who works with members of a New York City-based Medicaid managed care plan.

The outreach coordinators and the health

coaches work closely with the health plan's case management and other care management programs as well, Miniati says.

"We share what we do with the health plan and they share what they do. We work together to get help for the members so they can be healthier and stay out of the hospital," he says.

The program includes Care Coordination Grand Rounds during which Health Integrated's staff and the health plan's clinical leadership review the challenging cases and brainstorm ways to ensure that appropriate care is being delivered smoothly.

"We work together on the challenging cases and figure out the best way to manage them," he says.

Health Integrated takes the health plan's claims and other data and uses its proprietary predictive modeling tools to identify the highest-risk members who are eligible for the program.

"We also work with health plans to identify groups that may not fit into a particular algorithm but still might be challenging for the health plan to manage," Miniati adds.

For instance, one client requested that Health Integrated work with its Supplemental Security Income (SSI) patients whether or not they met the predictive modeling criteria.

When members are identified for the program, they receive an automated voice message telling them they will receive a mailing about a new program offered by their health plan.

After the mailing has been delivered, they receive an outreach call from engagement specialists who are trained to engage the members and educate them about the program.

"We don't talk about specific conditions. We talk about how we can help them work with their health care providers to feel better. We invite every member to work with a Synergy clinician, but we also offer them the option of participating in other ways," he says.

For instance, some members choose to receive help in managing their care through an e-mail or an interactive voice response system, mailings, or a combination of both.

If people are not reached or don't agree to participate in the beginning, Health Integrated reaches out to them on a regular basis to remind them of the program and their option to work with a health coach to improve their quality of life.

"When people don't engage in the beginning, we don't give up on them. We regularly ensure they know that the program is open to them. The whole idea is to stay in touch with the members until the point in time when they want to actively participate in the program and possibly engage with clinicians," he says.

When members agree to participate in the program, they are assigned a care coach who may be a licensed social worker, a psychiatric nurse, a licensed mental health counselor, a family therapist, or a registered nurse.

"We lean more toward the behavioral sciences because many members with exacerbated chronic illnesses also have psycho-social issues that have not been addressed. We identify and overcome the psycho-social barriers before we start working on the chronic issues," Miniati says.

The care coaches work with the members to establish long-term goals and start by working on short-term goals that will help them meet their long-term goals.

"We don't tie the goals directly to a condition, but look at long-range goals, like being able to go to a grandson's baseball game without getting tired out or feeling uncomfortable. A short-term goal might be something like walking a half block as a starting point," he says.

The care coaches also empower the members to better communicate with their physicians.

For instance, the member may not be following through with the treatment plan simply because he or she doesn't understand the doctor's instructions. The care coach works to increase understanding of the treatment plan and to frame questions for the member to address with the physician on the next visit.

Members typically work with the same clinicians for as long as they are in the program.

"By addressing the critical interplay between medical, psychological, and social health and by offering all targeted members with the opportunity to engage with a dedicated care coach, Health Integrated has established a program unlike any in the industry that delivers improved quality of life for members, better clinical outcomes, and lower health care costs," Miniati says. ■

## Look to your reinsurer for help on difficult cases

*Experts can help provide cost-effective care*

If you are managing the care of a catastrophically ill or injured patient who needs complex care planning, coordination of resources from

many sources, and a large allocation of financial resources that could cause the patient to reach his or her maximum lifetime benefit, it could be helpful to you and the patient to find out who may be sharing the risk.

Often, that means the company that provides reinsurance for the health plan or self-insured employer. Reinsurance companies often employ nurses who can assist with the medical coordination of complex cases.

"As a case manager, it is important to note what the health plan covers and when reinsurance is available as another avenue of funding and assistance," says **Barbara Tomlin**, RN, MS, CCM, assistant vice president, medical management for IOA Re Inc., a reinsurance underwriting company with headquarters in East Norriton, PA.

Reinsurance is stop-loss insurance for primary insurance firms or self-insured employer groups, Tomlin explains. When individuals experience catastrophic events with significant health care expenditures, those claims may become eligible for funding under the reinsurance policy, Tomlin says.

Reinsurance helps to provide a basis for financial security within an organization by adding another layer of protection against the dollars involved in caring for patients with catastrophic illnesses or injuries.

Once a patient's medical care exceeds a predetermined deductible, the reinsurer assumes responsibility for the costs. In some cases, the deductible can be as low as $20,000, a threshold easily attained with today's health care expenses, Tomlin points out.

Since the reinsurers assume financial risk only on catastrophic cases, they are likely to know the best professional or facility to tap into to optimize the outcomes for the difficult cases the case manager is handling. A reinsurer's medical management department may have access to national resources and be able to consult with their clients as to which providers or facilities have significant experience and positive outcomes.

"Care-making decisions and utilization review, however, remain the responsibility of the primary insurer or HMO," Tomlin adds.

Often, reinsurers are willing to get involved with a complex case even before the reinsurance benefits kick in.

"Once an insurance company or self-insured employer identifies a member who has the need for ongoing catastrophic care, they can call on us to provide assistance," Tomlin says.

Reinsurers prefer to be notified as early as possible so they can get a head start on finding the best treatment options for patients, she adds.

"We are often called in to provide assistance before the member needs a transplant, is anticipating entry into dialysis, or before a high-risk delivery. Proactive management is always most effective, as assessing and planning require collaboration for optimal care coordination," she says.

In another scenario, when someone has a spinal cord injury, the reinsurer prefers to be notified as soon as the patient is admitted to the acute care hospital.

"When our notice occurs early on, we can locate a center of excellence so that as soon as the patient is medically stable, we can arrange the transfer to a facility that can provide optimum outcomes in a cost-efficient manner," she says.

Reinsurers commonly encounter cases that are complex and costly, such as traumatic brain injuries, organ transplants, spinal cord injuries, oncology treatment, and dialysis. Some of the most difficult cases are with members who are being admitted for surgery but have multiple comorbidities and who experience numerous complications, Tomlin says.

"We don't provide hands-on case management but work in an advisory capacity to help the insurer's case manager identify resources that have been utilized successfully in the past," she says.

For instance, if a member needs a transplant, IOA Re works with four networks that provide specialty care and centers of excellence for transplant surgery.

Recently, Tomlin's company received a notice from a third-party administrator with chronic kidney disease who was facing dialysis or a possible kidney transplant.

The IO Re team referred the member for individual case management by an expert on kidney disease who was located in a nearby and cost-effective dialysis facility. She also assisted with coordinating more effective pricing options while educating the member about home dialysis so the member was aware of all possible treatment options.

"When it is appropriate, home dialysis is more clinically and financially advantageous to the members because they are utilizing less of their health care allocation and dialyzing daily," Tomlin says.

Because the member might elect to have a

kidney-pancreas transplant, the case manager identified centers of excellence for kidney transplant in the member's area.

The reinsurance company has the resources to identify which facilities or providers can provide the specialized care the member needs, and the medical management team regularly tries to keep abreast of additional services for clinical and financial assistance, she says.

"When a case manager at an insurance company is having difficulty in locating a specialist or a center of excellence, we will help identify the best source of care for the member," she says.

Often this involves calling in case managers who specialize in one particular area and who can give expert advice about the best avenues of treatment for the patient.

In the case of a patient with metastatic cancer, the company can contact an oncology management company and contract with a case manager who specializes in oncology treatment and who has researched the standard of care treatment options and appropriate clinical pathways.

"Today, there are so many clinical trial and research discoveries that it's difficult to keep up with the most appropriate types of treatment for a particular cancer. Our case managers and medical advisors assist us in researching and determining the best cancer treatment centers of excellence and protocols for the members' medical care," she says.

If an insurer has a member who requires complex care and is admitted to a medical center in a distant state, IOA Re may employ a case manager to go to the site and meet with the treatment team to make recommendations for a specialist consultation or continuing care in a long-term care facility or rehab facility.

Tomlin has been called in to assist an insurer early in a member's high-risk pregnancy.

"We know that there are conditions that put the expectant mother at risk or diagnostic testing that might confirm that the child has a potential congenital anomaly. We will employ a company that can provide medical advice to help the mother carry the child as close to term as possible," she says.

If the fetus is determined to have a congenital defect, such as a heart defect that might require a procedure within a week of birth, the case manager hired by IOA Re might recommend that the baby be delivered at a center of excellence that can perform the surgery in a timely manner.

Calling on the reinsurer for expert help can assist case managers in finding the best medical care and the best medical resources to manage the member's treatment in a way that makes the best of his or her health care maximum benefit, Tomlin points out.

Most health insurance policies have a $1 million to $3 million lifetime maximum, Tomlin says. Case managers need to know what the member's lifetime medical benefit is to assist the member in managing the cost of care to maximize that benefit, she says.

Some dialysis providers may charge up to $500,000 in one year for dialysis care, making it likely that an individual on dialysis could exceed his or her maximum benefit before becoming eligible for Medicare, she adds.

"To be an effective case manager and create the most desirable impact, it's just as important to understand the financial aspects as well as the clinical aspects of managing a complex case," she says.

When a patient's case is complicated, it may be more cost-effective and result in better outcomes if he or she goes out of town to a center of excellence rather than receiving treatment on the local level, she says.

In these cases, insurance case managers can work with their reinsurer to determine the most cost-effective treatment options, to identify centers of excellence, and to help the member understand the options that can optimize his or her medical benefits.

"Centers of excellence have demonstrated that they provide first-rate treatment, and they often can provide care for complex conditions at a contracted price and with better outcomes than a local contractor can provide," she says. ■

# DPs can address patients' adherence barriers

*Understanding and behavioral are big ones*

One key to discharge planning is understanding what might prevent your patient from following medication and other instructions.

Once you have an idea of what the patient's adherence barriers are, you can find solutions.

A substantial reason why continuity of care fails is that once patients are discharged, they're on their own with taking the medications they're

given and following their discharge instructions, says **Alan J. Christensen**, PhD, a professor in the departments of psychology and internal medicine at the Carver College of Medicine of Iowa City, IA. Christensen also is a senior scientist with the Veterans Administration Iowa City Health Care System.

Christensen describes the following potential barriers to discharge adherence:

• **Psychological barriers:** "Does the patient understand the instructions?" Christensen says.

Patients' mental status and cognitive capacity should be assessed to make certain the patients are capable of following a complicated set of medication instructions, Christensen says.

"There are related issues like the division of attention during this stressful time period," Christensen notes. "I've never been in a hospital as a patient, but I know things are happening fast and furious, and a patient's attention is divided."

Patients already have extra cognitive demands, so it makes it difficult for them to concentrate when a discharge planner asks them to think about medication instructions, he adds.

"It's not only the demented patients who have trouble," Christensen says. "Most of us would have less than perfect memory, processing, and attention in that situation."

• **Behavioral barriers:** Cognitive barriers relate to understanding the instructions, and behavioral barriers relate to acting on what's taught, Christensen says.

Just because a patient understands what the discharge planner says doesn't mean the patient will follow instructions, he adds.

The reason is that it's difficult to remember to take one's medications at certain times of the day, Christensen explains.

"This overlaps with the cognitive, but we address it separately," he says. "We address the cognitive barriers by simplifying the instructions, and we address the behavioral barriers by giving people pill boxes and memory aides to use."

Discharge planners can provide patients with behavioral cues that will remind them of how and when to take their medications.

For instance, a discharge planner can show a patient how the medication is taken by having the patient demonstrate taking the pills, Christensen suggests.

"And we often talk about linking medication administration with other daily tasks that are habitual, such as brushing your teeth," he adds. "So, you tell a patient to take his medication when he brushes his teeth in the morning and when he eats dinner at night, instead of saying he should take the pills in the morning and at night."

• **Social barriers:** For some patients, such as HIV-infected patients and diabetics, there might be a social stigma attached with taking medication or giving themselves injections, Christensen says.

"For younger, active patients there is a stigma associated with medication taking, particularly if it involves having to give yourself an injection before a meal if you're a diabetic," he says.

There also are patients who don't like to take their medications during certain social situations or when other people are around, Christensen adds.

Another social barrier includes transportation problems, such as not having a way to go to the pharmacy and pick up the prescriptions, he says.

For these patients, the solution might be to have them use a mail-order pharmacy.

"But if they can't use a computer and are not that good on the telephone, then it might be an issue," Christensen says.

So part of the discharge planner's job is educating patients about what options there are in terms of ordering prescriptions by mail and how to refill their prescriptions over the telephone or computer, he adds.

• **Financial barriers:** For some patients, the solution to financial barriers is to change their medication to generic forms, he says.

Other patients might need additional help, such as assistance from a hospital program that provides an initial supply of medications, Christensen says.

"But that depends more on the patient's long-term chronic regimen," he adds. "Because sending someone home with a seven-day sample of pills to get them started is not related to adherence over the long run." ■

# Patient perceptions guide discharge education process

*Patients often want more than what's allowed*

Transitions in health care are changing more quickly than patients' expectations, which is why it's important to address these expectations

head-on, an expert notes.

"That's been one of our greatest challenges — setting appropriate expectations," says **Pamela J. Tobichuk**, RN, ONC, a nurse case manager with the pre-admission orthopaedic total joint program at Massachusetts General Hospital in Boston. Tobichuk spoke about using a pre-admission prediction tool to improve the discharge process at the 18th annual conference of the Case Management Society of America (CMSA), held in 2008 in Orlando, FL.

Sometimes, patients will have a long lag time between when they are first told they will need elective joint therapy and when they actually schedule such therapy, Tobichuk says.

"They've had all this time before the surgery to build up expectations," Tobichuk says. "They might have a preconceived notion about what it is they'll do, and way back when they first met with the physician this was not part of the conversation or focus."

Another reason expectations might be different is that patients often have a friend, spouse, or neighbor who has been through similar therapy, and the way this other person's discharge was handled was different, she adds.

For example, it's possible the patient's husband had knee surgery a few years ago, and the spouse was discharged to an acute rehabilitation facility.

Now, because of payer and Medicare changes, this option is unavailable to the wife, and yet she expected that's precisely where she would go after discharge.

"Most times we ask the patient, 'What is your plan?' and the patient might answer, 'Oh, I'm going to Spaulding Rehab,' which is an acute rehab facility," Tobichuk says.

So, it's the discharge planner's/case manager's job to educate the patient about which options are available.

"I educate patients on the levels of care, home care, and even outpatient therapy," Tobichuk says. "We teach patients that they'll have some sort of therapy or rehabilitation, but we better define how this will be done."

For instance, low-risk patients who are highly motivated might be sent home and referred directly to outpatient therapy, she explains.

Mid-level risk patients might be sent home to receive home care, including therapy in the home, and high-risk patients might be discharged to a skilled nursing facility, where they receive physical therapy.

Occasionally, a patient will insist that a referral be made to acute rehabilitation.

In response, the discharge planner can say, "Ok, I'll put the referral in, but I'm telling you this is unlikely," Tobichuk says.

The key is to engage the patient in the conversation, obtaining the patient's ownership of the discharge process.

Patients who feel that their opinions and concerns were heard and who are well-educated on what will happen to them post-discharge often report reduced anxiety about the discharge process.

"I try to explain that everyone's situation is different," Tobichuk says.

"We look at every case independently, and we try to give them an opportunity to be proactive in their own discharge plan, to empower them to make some decisions about what they're going to need." ■

## To avoid disasters, be ready to answer these questions

*Don't act without support*

A company with 100 employees dedicates an entire floor of the building to a fitness center, but like many companies, has had financial setbacks due to the recession. Suddenly, the employee gym looks like a very bad investment.

As an occupational health professional, you could have seen this problem coming and saved the day by suggesting a different approach, says **Robert R. Orford**, MD, CM, MS, MPH, president of the American College of Occupational and Environmental Medicine and a consultant with the division of preventive occupational medicine at Mayo Clinic Arizona in Scottsdale.

In the above case, Orford says, it would have made more sense for this particular company to contribute toward employee membership at a local health club or even pay for memberships outright. For 100 employees, a $300 membership would be $30,000, or $15,000 if the company paid half the cost. "That is a lot less expensive than taking up a third of your building, and when the downturn comes, you can't get rid of it," says Orford. "Once you have invested 5,000 square feet in wellness, that infrastructure is not easy to get rid of."

Before you ask for specific resources needed for wellness initiatives, be sure that what you are asking for is appropriate. "Otherwise, you could easily be misled and do things that are not appropriate," warns Orford.

According to **Eileen Lukes**, PhD, RN, COHN-S, CCM, FAAOHN, health services manager for The Boeing Co.'s southern region, based in Mesa, AZ, "failure to anticipate the questions that upper management will ask will prevent you from having the answers needed to sell the program." Be sure you are ready with answers to these questions:

• **Are there any champions in upper management or at the executive level?**

Without knowing this in advance, you might end up in a dangerous position, without leadership buy-in or support of stakeholders such as the benefits department, says **Grace K. Paranzino**, MS, RN, CHES, FAAOHN, national clinical manager for Kelly Healthcare Resources in Troy, MI. "The heads of finance or benefits may have data to support the development of a program," adds Lukes.

You can identify champions informally through lunches, says Lukes, but it might require formal appointments to lay out your case and get a real commitment.

### *What's in it for them?*

To obtain buy-in, Paranzino recommends answering the question "What's in it for me?" for all stakeholders, both leadership and employees. "Ultimately, if leadership support is not strong, this message does trickle down to the employee level, and programs will fail because they will not be viewed as organizationally important."

• **Do you have the support of employees and/or unions?**

"Employees are the company's greatest asset. Getting and keeping good employees is the goal of every human resource professional and manager," says Lukes. "Further, companies strive to have good relationships with unions."

If employees, unions, and the company are working together toward a common goal, a company can expect greater employee engagement, says Lukes, leading to strong productivity.

• **What has been done elsewhere?**

Benchmark with your counterparts at other companies to find out what programs have resulted in success. "This will provide the framework for creating a program that is likely to get support," says Lukes.

In addition to basic questions about what the wellness program consists of and how much is being spent, Lukes says to ask other companies these questions about measured outcomes:

• Have you saved money?

• How do you know money has been saved?

• Has there been any measurable impact on disability costs or medical care costs? How are you measuring those things?

• Has there been an improvement in employee satisfaction or employee engagement scores?

• If you have a program but it's relatively new, what are the outcomes that you are measuring?

• **How is the health of the employee organization?**

**Catherine M. Pepler,** RN, ASN, MBA, COHN-S/CM, FAAOHN, director of site operations at Take Care Health Systems, a Conshohocken, PA-based provider of worksite health and wellness services and in-store health clinics, says this can be gleaned from the types of clinic visits, reasons for lost time from work, and health and wellness surveys of the employees.

"One other thing to consider is benefit utilization of the employees," says Pepler. "This is tricky, as companies do not readily share this information. But it is worth trying to obtain for analysis."

Before making a business case, "be cognizant and well versed in disease prevalence and severity for the target population," advises Paranzino. "Review the utilization data to determine costs of users, and prioritize programs accordingly." ■

## Don't make these 4 financial mistakes

When asking for resources for an occupational health initiative, you need to prepare a realistic program with solid goals and objectives; otherwise, you risk the program failing and your credibility diminished. Avoid these pitfalls:

• **Miscalculating the specific resources you will need**.

Money is just one thing you'll need to consider. Don't overlook administrative support, supplies, and the time employees will be away from the job. "Overstating your financial needs is just as detrimental as understating needs," says

**Catherine M. Pepler,** RN, ASN, MBA, COHN-S/CM, FAAOHN, director of site operations at Take Care Health Systems in Conshohocken, PA. "It will have an impact on obtaining funds for the next program request."

You'll need supporting data to justify the resources you are asking for, says Pepler.

Later in the process, Pepler says to provide a written outcomes report showing the resource use and the outcomes achieved. "A summary of the program elements, aggregate data, and follow-up plans for the next steps should be included in this report," she says.

**• Promising things that are unrealistic.**

Be clear about what will have an impact on the bottom line for the company. "Will the results lead to a reduction in lost time and disability? Will the results reduce turnover? Will there be a gain in productivity? Be realistic on the expected outcomes and state that clearly," says Pepler. "Overstating the gains can lead to loss of credibility."

**• Misleading others about when return on investment (ROI) realistically will come.**

Most wellness programs have a delayed impact and should be considered as long-term investments in employees. "Companies may not realize that they won't see an ROI until after one year," says **Eileen Lukes**, PhD, RN, COHN-S, CCM, FAAOHN, health services manager for The Boeing Co.'s southern region, based in Mesa, AZ.

For this reason, when telling others about the gains the company will see, always remind them that some of the outcomes will be readily recognized, whereas others will require time to surface, says Pepler.

**• Assuming that you know what employees want.**

If you fail to obtain employee input about what they want and perceive as important, you will likely face lack of participation, which will result in a decreased ROI, warns **Grace K. Paranzino**, MS, RN, CHES, FAAOHN, national clinical manager for Kelly Healthcare Resources in Troy, MI. "You want to have support from the top and from those who will be involved in the program," she says. ■



## COMING IN FUTURE MONTHS

- Helping clients with end-of-life issues
- Tailoring disease management to a multi-cultural world
- How worksite wellness programs can pay dividends
- Coordinating case management efforts in the community

# CE questions

12. Dania Anderson, LCSW, outreach coordinator for Health Integrated, says one challenge to meeting the needs of Medicaid population is they often don't meet appointments.
    A. True
    B. False

13. According to Barbara Tomlin, RN, MS, CCM, assistant vice president, medical management for IOA Re Inc., most health insurance policies have a $4 million to $5 million lifetime maximum.
    A. True
    B. False

14. Alan J. Christensen, PhD, a professor in the departments of psychology and internal medicine at the Carver College of Medicine of Iowa City, IA, describes potential barriers to discharge adherence. Which of these does he NOT address?
    A. psychological
    B. behavioral
    C. financial
    D. intellectual

15. Patients who feel _____ what will happen to them post-discharge report reduced anxiety.
    A. educated about
    B. concerned over
    C. not certain of

**Answers: 12. A; 13. B; 14. D; 15. 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. ■