Case Management ADVISOR™

Covering Case Management Across The Entire Care Continuum

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IN THIS ISSUE

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Health plan, physicians collaborate to improve patient care

Pilot project focuses on coordinating care for people with diabetes

A unique partnership between a health plan and a physician practice is helping patients with diabetes get the care and resources they need to manage their disease.

The patient-centered medical home pilot project focuses on people with diabetes who are members of BlueCross BlueShield of South Carolina, BlueChoice Health Plan of South Carolina, the State Health Plan, or BlueCross Blue Shield Federal and who are patients of Palmetto Primary Care Physicians in the Charleston, SC, area.

The pilot project began in April using a model that integrates quality improvement, coordinated care management, and patient educational services into primary care practices.

Case managers located in the physician practice corporate business office act as liaisons between individual physicians and their patients between visits. They collaborate with the health plan's disease management nurses and certified diabetes educators to help patients comply with their treatment plan, receive the recommended tests and procedures, and reduce gaps in care. The physician office-based case managers contact the patients by telephone to help them schedule appointments with specialists and access community resources when necessary.

"We believe that if patients become more educated and better able to self-manage their disease and physicians are enabled to deliver evidence-based care, patients will experience fewer hospitalizations and emergency room visits and enjoy a better quality of life," says **Laura Long**, MD, MPH, vice president of clinical quality and health management for BlueCross BlueShield of South Carolina.

The program should reult in overall lower costs for employers and less absenteeism as well, she adds.

"Our employers are interested in patients being healthier and at work. They're looking beyond lowering their costs for health care. They

want their employees to feel good on the job so they can be more productive in the workplace," she says.

Palmetto Primary Care Physicians receives the traditional fee-for-service reimbursement for the care they provide patients, as well as an additional fee per participant, per month that allows them to fund the case management program.

In addition, through BlueCross BlueShield of South Carolina's pay-for-performance program, the physician practice receives quality-based bonuses, which reward the practice for improving quality and outcomes.

"Before we began this project, case management wasn't a reimbursable service so it wasn't practical for the physician practices to have case managers. By realigning reimbursement, it allows them to provide a different type of service to support their patients and to take a more proactive approach to care. It helps the physicians focus on delivering evidence-based care and quality outcomes," Long says.

The program takes a proactive approach to care and reaches out to all patients who have been identified with Type 1 or Type 2 diabetes, Long says.

"In the past, programs focused on the most complex patients. All patients are eligible for this program. Rather than just treating the patients who walk in the door, the program also reaches out to the patients who are not coming in for services and helps them overcome the obstacles to seeking care," Long says.

Once patients are identified for the program, they receive a welcome letter from the physician practice and the health plan. The introductory packet includes information on the physician practice's extended care hours, an offer for a free glucometer from the insurer, and a blood sugar tracking booklet.

The case manager follows up with a telephone call to ascertain the patient's willingness to participate. Interested patients receive another packet with information on diabetes and tips for better nutrition, diet, and exercise.

The program is an opt-out program to which most have responded favorably when the case managers call to explain the project, says **Amber Winkler**, MHA, case manager with Palmetto Primary Care Physicians.

After the initial call, case management outreach is customized based on the needs and requests of the patients.

The physician-based case managers are non-clinical staff who provide support and resources for the patients and work with the BlueCross BlueShield clinical disease managers to ensure that patients get the clinical information they need.

Each physician-based case manager works with about 500 patients.

"We strictly avoid giving patients clinical advice. We concentrate on giving the patient the resources they need to follow their treatment plan," Winkler says.

For instance, the physician-based case managers make sure that the patients keep their appointments to see their doctor, facilitate referrals when needed, make sure that the patients' test results get back in the chart, and help

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patients overcome obstacles to adherence.

They provide additional resources to the patients, including free week passes and discounts to local gyms; cookbooks; American Diabetes Association-approved nutrition materials such as meal plans; diabetic education classes; free glucometers; discounts on prescriptions or free samples of medication; and patient assistance programs.

Patients have access to the case managers at the corporate office and their physician offices through a secure web-based portal.

"We look at information like their last appointment date, gaps in care, and their most recent laboratory values. We assess what they are willing to learn about and do to manage their condition. When patients need clinical advice, we help them interface with the BlueCross clinical diabetes educator and their physician's office," Winkler says.

The improved communication, coordination, and interaction between the physician offices and the health plan are unprecedented and are a key component of the program, Long says.

In the past, the two organizations tended to work in silos. Now they work together to make sure that the gaps in care are covered, she adds.

"Before we started this program, case managers and disease managers at the health plan level communicated with members and occasionally talked to someone in the physician offices. Under this model, we're tightly interfaced with the case manager in the physician office through an electronic link into the electronic medical record in the doctor's office," Long says.

"It's been a great arrangement for both of us. It's opened up a lot of communication between the physician practice and the insurer. Having direct contact with the insurer is a big help," Winkler adds.

For instance, the arrangement allows the health plan's diabetes educators to access patients' medical record and care plan as they work with them.

"The ability to follow through and the level of communication are significantly enhanced. The diabetes educators can add an electronic sticky note for the case manager or physician based on the conversation they've had with the member and vice versa," Long says.

By having access to the health plan's data, the physician office case manager can tell if the patient actually filled his or her prescription and can discuss it with the patient on the telephone and get the patient medication assistance or a coupon for a prescription if needed.

"We work so closely with the health plan and know our patients so well that we can advise them on the best way to get prescriptions or supplies. We have access to each patient's individual coverage so we can advise the patients what is best for them," Winkler says.

For instance, the case managers have suggested that patients consider generic drugs or a different glucometer because they would be covered under their plans.

One patient was paying out of pocket for his glucometer strips. Winkler advised him that his health plan would pay for the strips if he got a prescription for them and paid the copay.

"Benefits can be so complex and so difficult for patients to understand. We try to work out the best way for the patient to get what they need and pay for it so they will keep following their treatment plan," Winkler says.

The case managers take an individualized approach to each patient's unique situation, identifying why gaps in care occur and working to overcome the barriers.

"We look at whatever we can rearrange to make the situation workable. If the patient is on a high-deductible health plan and can't afford the deductible, we see if they qualify for a patient assistance program," she says.

They assist patients who are eligible for Medicaid supplemental insurance but need help filling out the paperwork.

In some cases, the case managers work with the health plan to get an out-of-contract social worker visit authorized as an alternative treatment plan.

"Within this pilot, we have the ability to be flexible on a case-by-case basis," Long says.

In one instance, a patient who had lost his job was afraid to come into the office with a broken toe and an infection because of financial problems. The case manager at the physician practice called the health plan to get approval for an office visit and get him help with his medication needs.

"The health plan bridged a gap until the physician office case managers could get other resources in place," Winkler says.

The physician office case managers have compiled a tremendous amount of information on community resources and other programs that can help patients overcome their obstacles to getting care or complying with the treatment plan.

"Since the case managers are in the Charleston area where the patients live, they are able to identify an amazing amount of community resources

that help patients overcome the barriers to care. The case managers at Palmetto Primary Care Physicians have wonderful social and organization skills, which help them connect with the patient and identify their needs. Anytime they need us, they can call us in and we'll get involved," Long says.

The physician office case managers work closely with the patients to make their health care dollars stretch.

"Many times when we get to know the patients, we find they are spending money unnecessarily on things that are covered by insurance and are skimping on things that they really need. We utilize every resource we can find to help the patients get what they need to keep their disease under control," Winkler says.

For instance, when the case managers can help patients find transportation assistance or get help with an electric bill, it frees up money to pay for medications, or if patients can get low-cost generic drugs, they can use the money they would have spent on drugs for their copay.

"It's kind of like a shell game, a matter of arranging and maximizing the patient's available dollars. The case managers have been very adept at identifying community and health plan resources to fill the gaps in care," Long says. ■

CMS through the continuum help keep patients healthy

Organization provides seamless continuity of care

A comprehensive case management program at Desert Oasis Healthcare that provides care coordination for patients throughout the continuum keeps patients healthier and out of the hospital. And it's cost effective.

"Our belief is that excellent patient care is also the most cost-effective care. We try to fill all the gaps in the health care system and give patients the support they need to stay healthy and out of the hospital," says **LaDonna Headley**, RN, director of case management for the IPA and medical group.

The case management program at Desert Oasis Healthcare has multiple components that work hand in hand to provide continuity of care for patients along the continuum, Headley says.

"We have different programs to take care of a patient's needs throughout the continuum of care. They can go from one program to another or be in multiple programs simultaneously, if needed," Headley adds.

Desert Oasis Healthcare is a team of primary care physicians and ancillary providers. The organization has headquarters in Palm Springs, CA, with offices located throughout the Coachella Valley area. The medical group is a full-risk provider with most of the health plans.

The Desert Oasis physician group provides care for about 22,000 seniors enrolled in Medicare Advantage and a total of 78,000 patients. The 30-day readmission rate for Medicare Advantage patients enrolled in Desert Oasis is between 11% and 12%, Headley says. This compares to an average of 19.6% readmitted within 30 days for traditional Medicare beneficiaries, according to a study in the April 2, 2009, issue of the *New England Journal of Medicine*.

Case managers who are employed by Desert Oasis work in local hospitals and nursing homes to ensure that patients get the care they need in a timely manner. Intensive case managers coordinate follow-up care for patients with complex needs and multiple comorbidities. Case managers follow up with patients who have been discharged from the hospital or the emergency department.

Desert Oasis' Living and Aging Well program provides an array of services for seniors, including in-home physician visits for homebound patients, disease management for chronic diseases, and health education programs.

In addition, Desert Oasis provides case managers on call around the clock so that if a patient or a physician calls, he or she always speaks to a live person.

"We're always looking at better ways to serve our patients. We want to be the GPS for our patients to help them navigate the health care system and to provide care that is coordinated and timely," Headley says.

The case managers call any patients who made an emergency department visit and those who are discharged from the hospital within 24 hours to ensure that they get follow up.

In addition, when patients make an emergency department visit or are admitted to the hospital, the case management team analyzes each case to determine what, if anything, could have been done to give them the service and medical care they needed to prevent the admission, Headley adds.

"We are always looking for gaps in care and ways that we can eliminate them," she adds.

Desert Oasis has its own staff of case managers

in four local hospitals and a regional tertiary medical center who work with the hospital case managers to coordinate care.

"Hospital case managers have numerous responsibilities, and our case managers help supplement their care coordination efforts. When a consult is ordered with a specialist, they make sure the consult is done in a timely manner that day and doesn't fall through the cracks in the system because the cardiologist office wasn't notified," Headley says.

The Desert Oasis case managers make sure that when the physician orders a test or procedure it gets done in a timely manner and the information is in the chart.

"We make sure there aren't discharge delays because of lack of transportation or because the information the physician needed wasn't in the chart," she says.

The Desert Oasis case managers spend time with patients and family members and assess the patient's support system and the situation at home to determine if the patient may need additional care after discharge.

For instance, there may be an elderly patient whose wife doesn't drive after dark. The case manager makes sure the discharge happens early in the day so he will have transportation available.

Often the hospital-based care managers identify high-risk patients who could benefit from other case management programs.

When they leave the hospital, patients receive a Desert Oasis discharge card with a dedicated number to call 24 hours a day, seven days a week with questions about follow-up care.

"We want to know about it if the patient has problems understanding his medication regimen or home health doesn't come when expected. Those are things that can lead a patient back to the emergency department," Headley says.

Desert Oasis's outreach clerical staff call patients after discharge to make sure they have a follow-up appointment with their primary care physician.

A nurse case manager follows up the day after discharge to make sure the patients have gotten their prescriptions filled, are not experiencing any problems, and that their support system is in place.

"We work closely with the emergency departments at our four local hospitals. If they identify patients in the emergency department who are not necessarily being admitted but need follow up, they call our case manager," she says. Desert Oasis has case managers on call around the clock.

It has developed an intensive case management program, staffed by RNs with emergency department and intensive care unit experience to coordinate care for at-risk patients with complex needs that aren't being met.

Patients eligible for the program have multiple comorbidities, are frequently hospitalized, make frequent visits to the emergency department, or have been diagnosed with cancer.

Referrals come from primary care physicians, emergency department staff, skilled nursing facilities, home health providers, and the physician group's customer service line.

When a patient is referred to the program, the intensive case manager reviews the patient's chart and immediately calls the patient to determine what is going on.

When the situation indicates it, the intensive case manager and a physician see the patient in the home, often within an hour of getting the call.

"Whether we see the patient in person or handle it by telephone depends on the patient and the patient's needs," Headley says.

The intensive case managers assist cancer patients to get all of the tests, such as biopsies, ultrasounds, and positron emission tomography (PET) scans, completed before they see the oncologist so the patients avoid repeated trips to the physician.

"When people are being diagnosed and treated for cancer, it's a frightening time. Our case managers support them and coordinate their care to ensure it occurs in a timely manner," she says.

One patient who received intensive case management was a Medicare Advantage patient who had made several visits to the emergency department in a short period of time because he was having prostate issues and couldn't void. The emergency department staff also noticed that the patient had a benign meningioma.

The patient needed to see a urologist but because he was an alcoholic had problems making and keeping appointments.

The urologist wouldn't operate until the patient had been cleared by a neurologist.

"There was no real likelihood that this man would be able to coordinate a visit to a neurologist, then get an appointment for prostate surgery," Headley says.

Desert Oasis got the urological problem controlled and enrolled the patient in a recovery program. He finished the program during the holiday season, and since he had no support system at home, the intensive case manager arranged for him to go to an assisted living center

for a couple of weeks.

The case manager then assisted him with the appointment to see the neurosurgeon to remove the meningioma, then supported him through prostate surgery.

Nearly a year later, he's still sober and his medical issues have been handled.

Desert Oasis Healthcare is part of The Heritage Companies, which include 25 medical facilities in California and New York. Richard Merkin, MD, COO, developed the model to manage medical groups and independent practice associations and integrate them with hospitals and ancillary care providers. ■

Use Case Management Week to educate

Oct. 11-17 puts spotlight on the profession

National Case Management Week, Oct. 11-17, is the perfect opportunity for case managers in all settings to educate their co-workers, the public, and politicians about the value of case management. But don't stop there.

Now that the lawmakers who are working on health care reform legislation recognize the value of care coordination and are including the concept as a quality standard for health care in legislation, case managers should continue their efforts to gain recognition for the profession, says **Margaret Leonard** MS, RN-BC, FNP, the new president of the Case Management Society of America (CMSA).

"The news is filled with talks of health care reform, and case managers are mentioned every day. People are finally beginning to recognize the value of case management. Case Management Week is an opportunity to promote the general good feeling that case managers are here to stay and that we're truly part of the solution," says Leonard, who is senior vice president for clinical services at Hudson Health Plan in Tarrytown, NY.

Regardless of what health care reform plan is adopted, it will open up a lot of opportunities for case managers, adds **B.K. Kizziar**, RN-BC, CCM, CLP, owner of B.K. & Associates, a Southlake, TX, case management consulting firm.

"We have a wonderful opportunity to bring case management to the forefront by educating our patients and our clients about how to manage their health and how to spend their health care dollars effectively. People need to know their options so they can make informed choices," she says.

Case managers have the information patients need, and they should share it with them and involve them in developing their treatment plans, she adds.

"The best way for case managers to be an advocate is to make sure they have the information they need to make an educated decision. People don't know what their options are or what their benefits are. Our goal should be to help them understand what is available and choose rather than just creating a plan and imposing it on a patient or client," she says.

Case managers are so busy with their jobs that sometimes they fail to explain what they do and how their work is going to benefit their patients or clients, Kizziar says.

"As a profession, it's up to us to spread the word, not only to the health care community but to the recipients of health care. National Case Management Week is a good time to start, but we should continue doing so throughout the year," she adds.

Kizziar suggests going a step further than just telling someone, "I'm your case manager and I'm here to help you with" your discharge, or getting back to work, or finding a provider covered by your health plan.

"Find out what they know about case management and move from there. Tell them why you're calling them or coming into their room. Rather than just being a person who shows up or calls them periodically, explain what you do and how it will benefit them," she says.

During Case Management Week, it's important that case managers in all areas of practice are recognized for the value they bring to the health care system throughout the year, Leonard says.

In your own organization, make sure everyone knows who the case managers are and what they do, she suggests.

Send out an e-mail to your entire organization telling them that it's Case Management Week and ask them to thank the case managers when they see them for their service to the institution.

"The more your case managers feel recognized and appreciated, the better they feel about themselves and their profession. A little praise goes a long way," she says.

If your budget allows, give your employees little gifts or certificates of appreciation. Bring in bagels in the morning or pizza for lunch, Leonard says.

"The celebration doesn't have to be anything expensive or elaborate, but it should remind everyone of the contributions that case managers make," she says.

Find out if your local chapter of CMSA is having a celebratory meeting or a mini-conference and encourage your employees to attend, Leonard says.

The Case Management Society of America's web site (www.cmsa.org) has a wealth of information on how to celebrate case management week, Leonard adds.

In some organizations, particularly hospitals, case managers are recognized during Nurses Week or Social Workers Month, instead of being celebrated on their own, Kizziar points out.

"That's in part because we, as case managers, have failed to educate our peers on the value that we bring to our work. We've been somewhat complacent about being lumped in with our clinical peers. We need to make a concerted effort, especially in today's health care environment, to make sure that the people we work for and the health care consumer know what case management is, and Case Management Week is the perfect opportunity to do so," Kizziar says. ■

Diabetes requires patients practice what they learn

Chronic disease management is a lifetime pursuit

"We don't say it is always easy to manage diabetes, but we do say that diabetes is a manageable disease," says **Janis McWilliams**, RN, MSN, CDE, BC-ADM, an advance practice diabetes specialist at the University of Pittsburgh (PA) Diabetes Institute.

The best way for people diagnosed with diabetes to learn self-management is to become knowledgeable about the chronic disease. Attending a diabetes education program helps a patient get off to a good start, she adds.

Sue McLaughlin, RD, CDE, president of health care and education at the American Diabetes Association (ADA) in Alexandria, VA, agrees. She says people diagnosed with diabetes need to become educated from a reputable source about diabetes management initially and continue to get updated about new therapies and approaches that promote successful management and healthy coping. She identifies reputable sources, such as the ADA web site (www.diabetes.org), certified diabetes educators, and providers who regularly attend seminars on diabetes management.

Patients, especially those newly diagnosed, should look for reputable information and discuss everything they learn with their provider and educators, according to **Marcia Carlson**, RD, MPH, CDE, metro diabetes education manager, Fairview Health Services in Minneapolis.

Often patients get information from family, friends, or the Internet and get bogged down in details that may not apply to them. Newly diagnosed patients often do not understand that diabetes is different for everyone, she adds.

Also important is an understanding that there is a difference between Type 1 and Type 2 diabetes, and that means the steps required to treat the chronic disease may differ according to the type, says **Marsha Mackenzie**, MS, RD/LD, CDE, diabetes program manager at Children's Medical Center Dallas.

About 90% of people diagnosed with diabetes are Type 2; however, children are more frequently diagnosed with Type 1 diabetes. Mackenzie says a lot of media focus is on the treatment of Type 2 diabetes, with coverage of such lifestyle changes as diet and exercise. However, with Type 1 diabetes, especially with children, the diet plan includes carbohydrates they would normally eat and promoting consistency, with an emphasis on normal growth and development, she explains.

"I think knowing what type of diabetes they have is instrumental in helping them manage," says Mackenzie.

Yet whether the diagnosis is Type 1 or Type 2, it is important that all people with diabetes acknowledge it as a chronic disease.

"A person can't just take a pill and forget about it," says McLaughlin. The management that promotes good control of blood glucose (sugar) and other aspects of the disease is for life and requires constant attention and adjustment.

"People need to know that it does take a lot of time, thought, and support to have healthy outcomes and a long healthy life," adds McLaughlin.

Mackenzie helps families being treated at Children's Medical Center Dallas wrap their mind around the idea that diabetes is a chronic disease by telling them there will be seasons, stages, or cycles when it will be more difficult to manage the diabetes. For example, a child's mother might return to the workforce after staying at home for a time, and, therefore, is not always available to help with food choices and other decisions.

"The challenges of caring for the disease throughout life make it such that we have to constantly work on different ways to cope and readjust and then make small strides to successful management," says Mackenzie.

Lessons in application

Yet small steps equal big successes, says **Cris Hartley**, RD, CDE, manager of diabetes and nutrition information at Gwinnett Medical Center Glancy Campus in Duluth, GA.

"In our diabetes classes, we help people to acknowledge the emotions that go along with the diagnosis, to listen, learn, and discuss what diabetes management is all about — then choose one small area in their lifestyles that they feel they might be able to tweak to start to move toward a healthier lifestyle," she adds.

When newly diagnosed, people with diabetes experience a wide range of emotions from anxiety and fear to being overwhelmed, and they often try to do too much too fast, she explains.

To determine a good plan for diabetes self-management, people need to learn about themselves, says Hartley. They need a basic understanding of what their own needs are in relation to their diabetes and how it affects them. They need to be able to identify areas in their lifestyle that may not be conducive to good diabetes management. They need to know what motivates them to make a change.

"Our best tool for helping patients overcome barriers is teaching them how to problem-solve. Identify what is getting in the way or causing a certain behavior, then doing some brainstorming to eliminate or reduce the barrier," says Hartley.

According to **Teresa Benge**, RN, CDE, CPT, a diabetes educator at Fairview Diabetes Care in Wyoming, MN, her job as an educator is all about problem-solving. She studies a patient's chart before they come in for education to identify the problem areas and try to come up with solutions.

"If you are genuinely trying to help and are willing to work with them, they are more willing to work with you," says Benge.

She has brainstormed strategies with many patients. For example, one patient liked to eat in fast food restaurants and did not want to change her lifestyle. Therefore, Benge helped her go through a calorie book to figure out the best choices in the restaurants she frequented. The patient keeps the information on a notepad in her purse, so she has a meal plan figured out ahead of time.

McWilliams has found diabetes education conversation maps useful in classes. These 4x6-foot maps, produced by a company called Healthy Interactions, cover different aspects of diabetes education and initiate a conversation among the participants. Included are activities that help people retain what they learn, says McWilliams.

Food models are another favorite educational tool for diabetes educators, says McWilliams. She says they help teach patients about portions. For example, patients would be able to see what size apple is a proper portion to help with counting carbohydrates.

Often, patients will need help when applying the information they are learning to real-life situations, especially when newly diagnosed, says Mackenzie. For example, a child might have low blood sugar after exercising, and families want to know why that occurred and how to handle the situation. Families are encouraged to e-mail or fax blood sugar numbers to the diabetes center during the first several weeks of treatment, so educators can review them and offer suggestions.

In the diabetes classes at Children's Medical Center Dallas, many hands-on exercises are included to help families apply the information to real-life scenarios and learn to solve problems. For example, class participants practice reading food labels. In a class called "Take Charge," families learn more about insulin-to-carbohydrate ratios and trends of blood sugar and how to adjust the insulin based on the center's guidelines.

Education for Type 1 diabetes is different from Type 2 diabetes in that patients and families must be taught core survival skills quickly that include checking blood sugar, proper administration of diabetes medication, how to treat high and low blood sugar, and basic carbohydrate counting, says Mackenzie. At Children's Medical Center Dallas, families begin classes a couple of weeks after diagnosis to learn more about the survival skills, and at that time new topics are added, such as how to successfully eat out at restaurants and how to navigate holidays.

Mackenzie says what makes diabetes education challenging is that every patient's take on it and ability is unique, so educators must fashion the information in a way that helps each achieve success.

"We try to make these real-life scenarios play out for them, but we are constantly learning that there are some situations where we may be able to do it a little better next time — or that particular family

needed to be approached from a different way. So, diabetes education is an art as much as a science, because you really have to fashion it so that the families feel empowered," says Mackenzie. ■

Addressing barriers to good self-management

Issues must be addressed to put education into practice

Many factors keep people from putting into practice what they have learned about diabetes. One frequent factor is that people do not make diabetes management a priority, says **Teresa Benge**, RN, CDE, CPT, a diabetes educator at Fairview Diabetes Care in Wyoming, MN.

For example, young working adults with families frequently say they do not have time to do all that is required. To address this barrier, educators at Fairview Diabetes Care often use motivational interviewing to help their patients figure out what they want to do with the rest of their life and how to best accomplish it. Basically, when patients identify their priorities, they realize their own health has to be No.1, explains Benge.

At Children's Medical Center Dallas, motivational interviewing is used to more formally assess such things as readiness to make certain changes. Patients and families having trouble coping with the diagnosis may need clinical counseling or psychological supportive measures, says **Marsha Mackenzie**, MS, RD/LD, CDE, diabetes program manager at Children's Medical Center Dallas.

A big part of teaching is understanding what frame of mind people with diabetes are in and how ready they are for the education, says Mackenzie. Many factors pose barriers, such as life circumstances, personality type, and temperament, as well as readiness to learn and apply techniques of disease management.

Janis McWilliams, RN, MSN, CDE, BC-ADM, an advanced practice diabetes specialist at the University of Pittsburgh Diabetes Institute, says depression over the diagnosis may occur, and it must be addressed, for a patient is not likely to manage diabetes well if he or she is depressed. Some consider complications from diabetes inevitable and must learn they can live a long, healthy life if they learn how to manage the disease. Those with no insurance or inadequate coverage may have financial barriers to good self-management of diabetes.

Marcia Carlson, RD, MPH, CDE, metro diabetes education manager, Fairview Health Services in Minneapolis, says often people cannot afford their medications, test strips, needles, or even nutritious food. Some cannot take breaks at work to test their blood glucose levels. She says she tries to refer patients to financial workers, pharmacy programs, and free or reduced medication programs. Also, she suggests cost-effective ways to get food.

Because people with Type 2 diabetes do not necessarily have any real symptoms when diagnosed, they may be inclined to ignore their disease. However, diabetes is not something to be ignored, says McWilliams. Failure to manage diabetes and keep blood sugar levels under control will eventually result in complications.

Today, people with diabetes can monitor their blood glucose with meters to determine how the foods they eat affect their blood sugar level either positively or negatively, says McWilliams.

Benge has patients take a blood sugar reading before a meal and then a few hours after the meal to figure out how the foods they are eating impact their blood sugar. When they take the time to check, they can figure ways to control their blood sugar, says Benge.

Diabetes management is a lifelong learning process, says McWilliams; therefore, she suggests that those diagnosed with diabetes be encouraged to build a diabetes education management team. Getting referred to a good educational program gives patients an opportunity to make contact with diabetes educators, as well as others who have been diagnosed with the chronic disease.

It is good to build a support network, says McWilliams, which might include attending a support group regularly. "It is very helpful for people to share what has worked and what has not worked with others who have diabetes," she adds.

Diabetes support groups are a good way for people to continue their education over time, says Benge. Guest speakers are invited to the support group she oversees to cover such issues as stress management for better disease control.

Patients and families may be doing very well at counting carbohydrates and checking blood sugar levels, but then something will occur that makes these same skills more difficult to perform. At this point, they may need the intervention of a health specialist or social worker, rather than at the point of diagnosis, says Mackenzie.

"It is really important to give them a schematic

view of diabetes and let them know there are places in which they may need support in a new way or more in-depth way than at other points in their care," says Mackenzie. ■

ID domestic violence, create a place of safety

You can and should intervene

If you had to name something that costs American businesses an estimated $4.1 billion a year in direct medical and mental health care services, would you think of intimate partner violence?[1]

Almost a quarter of full-time employed adults (21%) were victims of domestic violence, according to a survey done by the Corporate Alliance to End Partner Violence, and 64% of this group indicated that their work performance was impacted significantly.

"I think the occupational health nurse (OHN) would be surprised if they knew how much it costs," says **Sarah Katula**, PhD, APN, a clinical nurse specialist at Behavioral Health Services, Advocate Good Samaritan Hospital in Downers Grove, IL. "I also think they would be surprised at how effective they could be if they championed the issue." **[A free Domestic Violence Cost Calculator is available online, which computes the annual medical and absenteeism cost of intimate partner violence in your workplace. To use the calculator, go to www.texashealth.org. Under "Community Commitment," choose "Family Violence Prevention" and then "Family Violence Prevention/Cost Calculator."]**

"There are costs involved in domestic violence for the workplace that employers do not realize," says **Kim Wells**, the organization's executive director. "Occupational health professionals are certainly on the frontline of this. They may see presenting issues that are not domestic violence on the face, but are so on a deeper level."

Here's what to do

Katula says occupational health professionals should "provide a place of safety in their offices and extend that into the greater work environment." She recommends you provide screening and resources to employees by doing the following:

• **Offer general education to employees so they too know what to look for in other employees.**

"Often it is the coworkers that identify it because they see the day-after-day consequences," says Katula. "They may overhear phone conversations from the perpetrator. They may be asked to help screen calls or prevent the abuser from entering the workplace."

However, Katula says that the occupational health nurse (OHN) "could be the one to notice a bruise. She could be the one that asks screening questions in a way that if a 'yes' answer is there, the victim might disclose abuse." **(To find employer-based materials, go to www.caepv.org. Click on "Start a Workplace Program.")**

• **Assess how much leaders know**.

Katula sent managers a questionnaire on their knowledge of intimate partner violence, including any training they had received.

"We found that they had little experience, and knew very little about how to respond and what resources were available," says Katula. "We also found they were unaware of legislation to help protect abused employees." Based on these findings, training programs and an Intranet web site were created.

• **Obtain training from local domestic violence experts or agencies.**

"Training will provide you with a framework for what needs to be cultivated at your workplace," says Katula. "At Good Samaritan, we have a very close working relationship with two agencies: a police department and the YWCA. We meet monthly and formulate plans for education and awareness."

Reference

1. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Costs of intimate partner violence against women in the United States. 2003. Atlanta. ■

Screening may provide only modest benefits

Checking for partner violence didn't yield changes

New research suggests that universal intimate partner violence (IPV) screening in health care settings does not result in significant changes

in subsequent reports of IPV or quality of life, according to a study in the Aug. 5 issue of the *Journal of the American Medical Association*.

There is a lack of consensus on the issue of screening women for IPV in health care settings. Proponents support screening because of the high prevalence of IPV and associated impairment and the availability of feasible screening techniques. But organizations such as the U.S. Preventive Services Task Force and the Canadian Task Force on Preventive Health Care have concluded that insufficient evidence exists to recommend for or against universal screening, mainly due to lack of interventions that have been proved effective for women exposed to violence and referred from health care settings. "Nevertheless, clinicians and health care organizations are being encouraged to implement IPV screening. Numerous professional societies recommend routine IPV evaluation, assessment, and/or screening as a part of standard patient care, and the standards of The Joint Commission require that hospitals have objective criteria for identifying and assessing possible victims of abuse and neglect," the authors write.

Harriet L. MacMillan, MD, MSc, FRCPC, of McMaster University, Hamilton, Ontario, Canada, and colleagues examined the effectiveness of IPV screening and communication of a positive screening result to clinicians in health care settings, compared with no screening, in reducing subsequent violence and improving quality of life. The randomized controlled trial was conducted in 11 emergency departments, 12 family practices, and three obstetrics/gynecology clinics in Ontario, Canada, among 6,743 female patients, age 18 to 64 years.

Women in the screened group (n = 3,271; 347 positive for abuse) self-completed the Woman Abuse Screening Tool (WAST). If a woman screened positive, this information was given to her clinician before the health care visit. Subsequent discussions and/or referrals were at the discretion of the treating clinician. The non-screened group (n = 3,472; 360 positive for abuse) self-completed the WAST and other measures

COMING IN FUTURE MONTHS

- How technology can help with disease management
- Helping patients overcome behavioral barriers to care
- New career opportunities for case managers
- Case management through the continuum

CE questions

13. In the patient-centered medical home pilot project, case managers are located in the
    A. physician practice corporate business.
    B. hospitals.
    C. physicians' officers.
    D. none of the above

14. At Desert Oasis Healthcare, the 30-day readmission rate for Medicare Advantage patients is about ___?
    A. 5%
    B. 11%
    C. 19.6%
    D. 22.1%

15. Diabetes is a manageable disease, according to diabetes educators. To learn self-management, people would benefit most from which of the following?
    A. Attending a diabetes education program.
    B. Discussing diabetes with friends.
    C. Doing lots of internet research.
    D. Taking a pill and forgetting about the disease.

16. People can fail in their efforts to manage diabetes effectively because they do which of the following?
    A. Make too many changes too fast.
    B. Become overwhelmed.
    C. Overlook barriers to good management.
    D. All of the above.

Answers: 13. A; 14. B; 15. A; 16. D.

CE objectives

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

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

CE instructions

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

after their visit. Women who disclosed past-year IPV were interviewed at the start of the study and every six months until 18 months regarding subsequent incidents of IPV and quality of life, as well as several health outcomes and potential harms of screening.

The authors add that even though screening might provide some small benefits on some outcomes, "It is critical to balance the number and magnitude of potential benefits of universal screening with the human, opportunity, and resource costs required. ■