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

AHC Media LLC

IN THIS ISSUE

Financial disclosure:
Editor **Mary Booth Thomas**, Associate Publisher **Russ Underwood**, Managing Editor **Jill Robbins**, and Nurse Planner **Betsy Pegelow** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

JANUARY 2010
VOL. 21, NO. 1 • (pages 1-12)

2010 may bring new career opportunities for case managers

Value of care coordination is being recognized

Now is a good time to be a case manager, leaders in the field report. New opportunities are opening up for case managers as the country struggles with ways to provide optimal health care for everyone while minimizing soaring costs for care.

"Care coordination, case management, and safe transitions of care can only help save health care dollars. More and more, case management is being recognized as a valuable service and people are beginning to understand how the care coordination piece benefits the bottom line," says **Margaret Leonard** MS, RN-B, C, FNP, senior vice president for clinical services at Hudson Health Plan in Tarrytown, NY, and president of the Case Management Society of America (CMSA).

All of the health care reform bills that were introduced in Congress include the concepts of care coordination, care management, and safe transitions of care as cost and quality essentials for health care, Leonard says.

In addition to giving input on health care reform proposals, CMSA has been asked to provide language for a model case management act, she adds.

The Case Management Model Act is not a bill, but rather a document that educates legislators and regulators to help them define criteria for care coordination, case management, and transitions of care. It includes case management standards of practice, which contain a list of criteria that must be met before someone can call himself or herself a case manager, Leonard says.

"I feel good about the health care reform measures as they apply to case management. I think they will open up new avenues of practice for us. I don't think primary care physicians or other providers who don't already have case managers on staff will not go start hiring them until something is decided about health care reform including the realignment of incentives; but once we get past this hump, we're not going to

see any problems with nurses and social workers getting positions," Leonard adds.

Nancy Skinner, RN, CCM, agrees that case managers will have new opportunities in the future.

"It's going to be a whole new world for case managers. The case manager is going to become a consultant who helps the patient, the family, and caregivers have quality of life through the end of life," says Skinner, a consultant for Riverside HealthCare Consulting in Whitwell, TN.

Some of the opportunities for case managers will depend on what the final health care reform legislation looks like, Skinner says.

Case Management Advisor™ (ISSN# 1053-5500), is published monthly by AHC Media LLC, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to ***Case Management Advisor***™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $399. Add $17.95 for shipping & handling. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. For approximately 15 CE nursing contact hours, $449. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $67 each. (GST registration number R128870672.)

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider # 14749, for 15 Contact Hours.

This activity has been approved by the Commission for Case Manager Certification for 18 clock hours.

This activity is valid 24 months from the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editorial Questions

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

For instance, the idea of a patient-centered medical home is under discussion, and is likely to involve case managers in some way, Skinner says.

However, there's still no agreement on how physicians will be reimbursed for providing the extra services to patients, she points out.

"In today's economy, we truly need to focus on appropriate case management, but it all depends on the funding. I believe that case managers will become a part of primary care practices, but it may take as long as five years to determine how the patient-centered medical home is going to be organized and how case managers will participate," she says.

The incentives have to be aligned appropriately for primary care physicians to add case managers to their practice, Leonard adds.

"We can't ask primary care physicians to provide care coordination and not receive increased reimbursement. They're going to have to hire staff, and the government is going to have to reimburse for it," Leonard says.

The medical home model includes case managers who work with physicians to manage the care of patients, something that is sorely needed, adds **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president and founder of Mullahy & Associates, a case management training and consulting company.

"The health care system has become so complex that people need someone to act as their advocate. As physicians are forced to decrease the time they spend with patients in their office, and more responsibility shifts to the patient and family members, people need someone to guide them in making the right choices and following their treatment plan," Mullahy says.

Case managers can help people understand their diagnosis, make informed choices about treatment options, prevent complications, and save money at the same time, Mullahy says.

"However, the average person doesn't understand how much help a case manager can be, and that's why we need to educate them," she says.

Case managers based in physician offices can help patients understand how to manage their condition, how it will improve their quality of life if they do, and what could happen if they don't, says **B.K. Kizziar**, RN-BC, CCM, CLP, owner of B.K. & Associates, a Southlake, TX, case management consulting firm.

"We hear so much about noncompliant patients who don't fill their prescriptions and don't take their medications correctly, but there is

very little education that occurs at the doctor's office level when a new prescription is ordered or a new diagnosis is made. Patients need to be educated about how to adhere to their treatment plan, and case managers are the right people to do so," she says.

Sometimes patients can't afford their prescription and need help looking for alternatives, Kizziar points out.

"Doctors decide what is appropriate and rarely ask if the patient can afford it. I think people leave the doctor's office without the knowledge they need to make the kind of decisions they need to make. This is another opportunity for case managers," she says.

Whatever happens with health care reform, it is likely to be more and more difficult for middle-sized and smaller employers to continue to provide the same kind of health care coverage they do today, and that is likely to create opportunities for case managers, Kizziar points out.

She sees opportunities for case managers either as consultants on a contract basis or as employees who can help employees navigate the health care system, she says.

"As more and more people shop for health care benefits, case managers have an opportunity to share their expertise and act as consultants to employees to help them make wise decisions," she says.

Being a health care educator and advisor to help employees navigate the health care maze is an opportunity case managers haven't had in the past, she says.

"I have believed for a long time that case managers should inform the health care consumer about how to make better decisions and how to be compliant. This is going to be even more important in the future," Kizziar says.

The complex health care system and the emphasis on efficient and effective care already is creating opportunities, Mullahy points out.

"More and more third-party administrators are bringing case management and disease management programs into their organization. Employers are starting to look at opportunities for case managers. Hospitals are advertising for nurse navigators to help patients navigate their way through the health system and to manage their care once they are discharged," Mullahy says.

With the current emphasis on readmission rates, case management responsibilities in the acute care setting are likely to expand, and extend into the community, Skinner says.

"The focus on readmissions is going to increase the value of case managers and create a greater need for case management," Skinner says.

Data compiled by the Centers for Medicare & Medicaid Services (CMS) show that about 20% of patients responding to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) replied no when asked if anyone told them what they needed to do at the next level of care, Skinner points out.

"As health care reform rolls forward, I see case managers taking a role after patients are discharged from the hospital to help prevent an adverse event that could result in a rehospitalization," Skinner says.

For instance, heart failure is a major cause of rehospitalization within 30 days of discharge, Skinner says.

"Case managers can have a significant role in working with these patients to prevent readmissions. I predict that in the near future CMS will announce an intention to modify or discontinue payments for readmissions within 30 days. If and when this occurs, hospitals are going to have to develop a case management program for heart failure patients after discharge, or they're going to lose reimbursement from Medicare. Case managers in acute care are going to have to pick up a much greater role in transitions of care," she says.

Skinner predicts that in the future, case managers will work in every health care environment where there is a transition of care — skilled nursing facilities, long-term acute-care hospitals, home care agencies, and hospices.

"As patients move from one level of care to another, it's going to be the responsibility of the facility discharging them to give them the tools they need to be successful at the next level," she adds.

The aging baby-boomer population is going to be the catalyst for change, she adds.

"I can see case managers working in clinic environments and educating patients on what is wrong, what the patient needs to do, and why it is important," Skinner says.

For instance, joint replacement patients could benefit from having a case manager work with them before surgery, during the hospitalization, and after discharge, she adds.

Case managers can help with transitions of care by facilitating communication between providers and making sure providers at each level of care have all the information they need to treat the patient.

"Many times, patients are seeking care from

many different providers who don't always communicate with each other," Leonard points out.

For instance, if a patient is hospitalized or sees a specialist, the family doctor may not know what has been going on.

With the current system, if the primary care physician refers a patient to a specialist, that doctor should get the information back to the primary care physician. It doesn't always happen because no one is responsible for sending the information or ensuring that the primary care physician receives it, Leonard points out.

"In the future, because of the economy, many different levels of providers are going to pop up. We've already seen patient navigators and care coaches," Leonard says.

The new types of providers may be less skilled and less educated than the clinicians who provide direct patient care, but they're also less expensive, she adds. This means it will be more economical to hire a less skilled person to do jobs that don't need the expertise of a licensed clinician.

"Case managers are likely to be the people who will have oversight over the less expensive health care worker. The National Quality Forum has suggested in their work, which was published for public comment, that the care coordination team has to be led and overseen by a licensed health care professional. I don't think the public is going to let that idea die. They want to feel protected in what they are doing," she says.

(For more information contact: ***B.K. Kizziar****, RN-BC, CCM, CLP, owner, B.K. & Associates, e-mail: BKANDASSOC@att.net;* ***Margaret Leonard****, MS, RN-B, C, FNP, senior vice president for clinical services, Hudson Health Plan, e-mail: mleonard@HudsonHealthplan.org;* ***Catherine M. Mullahy****, RN, BS, CRRN, CCM, president and founder, Mullahy & Associates, e-mail: cmullahy@mullahyassociates.com;* ***Nancy Skinner****, RN, CCM, consultant, Riverside HealthCare Consulting, e-mail: casemanager@mac.com.)* ■

Want to spend more time interacting with patients?

Here are two opportunities to consider

Case managers went to nursing school to take care of people, something they find themselves doing less and less in most practice settings, **Catherine Mullahy,** RN, BS, CRRN, CCM, points out.

"Nurses like to feel like they are making a difference for patients, that they are part of the solution to their patients' health care issues. Case managers who spend a huge amount of time with their heads in a chart or talking to insurers aren't feeling good about what they are doing. Instead of spending time with patients, they're spending time on paperwork and business issues," adds Mullahy, president and founder of Mullahy & Associates, a case management training and consulting company.

In the future, as people need more and more help navigating the health care system, case managers are going to have the opportunity to have much more personal and face-to-face contact with patients, she says.

Direct-to-consumer case managers and guided care nurses already are providing face-to-face case management and developing a close relationship with their clients, she adds.

Guided care nurses

Guided care nursing gives RNs an opportunity to do what they went to nursing school for in the first place, says **Kathleen Trainor Grieve**, RN, BSN, MHA, CCM, a guided care nurse from Johns Hopkins Healthcare who works at Johns Hopkins Community Physicians at White Marsh.

The guided care model was developed by an interdisciplinary team of clinical researchers at Johns Hopkins University to improve the quality of life and efficiency of resource use for people with complex medical conditions.

Guided care nurses work in the primary care setting to coordinate care for patients with chronic conditions and complex needs, working side by side with the primary care physician, and interact with other health care providers who treat their patients.

"We are partners with the primary care physicians, the patients, the families, and the specialists. We take a holistic approach to patient care and are truly part of the whole team," she says.

Unlike nurses in other settings, guided care nurses never lose track of their patients after a brief episode of care because they work with their patients on a long-term basis, usually for life, Grieve points out.

They develop a close working relationship with patients and their caregivers and meet with them in their homes as well as accompanying them to physician visits and visiting them in the

hospital. They coordinate transitions between levels of care and providers.

"Some patients have said that working with a guided care nurse is like having a nurse in the family. Someone they trust is looking out for them and getting them the care they need," Grieve says.

Following an at-home assessment and evidence-based planning process, the guided care nurse monitors patients proactively, promotes self-management, smoothes transitions between sites of care, educates and supports family caregivers, facilitates access to community resources, and coordinates the efforts of health care professionals, institutions, and community agencies.

"Self-management is an important aspect of the program. We don't do things for our patient that they can do for themselves. We focus on helping them take charge of their own health," she says.

Guided care nurses come from a variety of backgrounds, Grieve says. Of the seven nurses in a three-year trial of the guided care nurse program at Johns Hopkins, one nurse had geriatric experience, another was an experienced home care nurse, and another had been a hospital-based nurse for only four years.

"It's not so much the experience nurses have had that make them a successful guided care nurse. It's their personal attributes," she adds.

For instance, guided care nurses have to be assertive when they need cooperation from the physicians, especially when they are just starting with the practice.

"Doctors are all overworked and have limited time. You can't let it stop you when they tell you they don't have time to talk," she says.

Guided care nurses must complete a guided care nursing curriculum and pass a certification examination.

Direct-to-consumer case managers

Direct-to-consumer case managers are nurses who are independent business owners and contract with patients and/or their family members.

While the contract for the actual services may be with the patient, referrals may come from group medical practices, elder care attorneys, financial advisors, small employee groups, and others who are aware of the benefit of the services.

Their fees are paid by the person who hires them.

"There's a tremendous need for case managers to help consumers navigate the health care system. Direct-to-consumer case managers help patients understand their diagnosis, their treatment plan, their medications, and help when nobody else has the time to answer their questions. They are the patient's advocate and someone patients and family members can call on when they have questions and concerns," Mullahy says.

When patients are seeing five or six different doctors, they need a case manager who can go with them to their appointments, help coordinate the care, and ensure that all of the providers have the information they need to develop a treatment plan.

"This type of practice gives case managers an opportunity to work one on one with patients and to develop a close relationship with them. It goes back to the first generation of case management where the case managers spent time with their patients. Direct-to-consumer case managers can control their own caseload and decide the best way to handle their cases," she says.

Direct-to-consumer case managers are not employed by a managed care organization, a hospital, or another entity.

"They represent the patient's interest and only the patient's interest. They don't face the challenge that their employer may want something that conflicts with what they think is the patient's best interest," Mullahy says.

Geriatric case managers have been contracting with family members or elder care attorneys for a number of years and managing the care of elderly patients, often when their family members live in another state, Mullahy says.

Other case managers have gone into business to consult with patients who are undergoing cancer treatment or have complicated conditions, such as congestive heart failure or end-stage renal disease, she adds.

Direct-to-consumer case management is a growing field that is likely to increase in the future, but it's not for everyone, Mullahy says.

"Just because someone is a wonderful case manager, they don't necessarily have what it takes to become a business owner and market their own services," she adds.

Offering your services as a consultant to consumers is fulfilling but is challenging because many case managers can't afford to go out on their own and lose the security of a weekly paycheck, she says.

Mullahy advises case managers who would like to try direct-to-consumer case management to keep their job and build up their practice in their spare time.

"I wouldn't advise anyone to leave the security of a job unless they have savings and other income," she says.

(Johns Hopkins is offering a six-week, 40-hour online guided care nurse course through the Institute of Johns Hopkins Nursing. For more information, visit www.ijhn.jhmi.edu.) ■

Program helps patients adhere to regimen

Members targeted have chronic conditions

Recognizing that patients who don't take medication for chronic conditions as prescribed are more likely to have poor control over their independence, Blue Cross has launched a program to coach people on medication adherence.

"We know that adherence to medication is an important part of managing a chronic disease. Members who have a chronic condition and don't adhere to their treatment have a greater potential for hospitalizations and outpatient care as well as a decrease in the quality of life," says **Kimberly Siejak**, manager of population health and wellness for the Philadelphia-based health plan.

The medication persistence program, launched in July as part of the Independence Blue Cross Connections Health Management Program, targets members who have not been adherent in taking medications for coronary artery disease, heart failure, diabetes, and/or hypertension.

"We targeted these conditions because they often can be controlled with medication and patients typically experience long-term complications if they don't take their medication regularly," Siejak says.

Many of the patients in the program have heart failure, a condition that frequently results in rehospitalization, she adds.

"Often when heart failure patients are in the hospital, they are discharged with a new medication and they're not sure if it is different from the one they were taking before they were hospitalized. Our health coaches can contact them and discuss whether they were prescribed a new medication, if they have a follow-up visit scheduled with their physician, and to answer any questions they have," she says.

The health plan included hypertension in the program because people with hypertension may stop taking their medication and not experience any immediate symptoms and can experience severe long-term complications such as strokes, she points out.

Independence Blue Cross uses medical claims data and pharmacy claims data to identify members with chronic conditions and members who have been refilling their prescriptions for chronic diseases less than 50% of the time.

"We don't know what happens after members fill their prescriptions. We hope they are actually taking it. The data we use for this program do give us a measure of the refill rate, which may be a proxy for the member's medication adherence," she says.

The health plan's proprietary algorithm risk stratifies members into low, medium, and high risk categories. Each category receives a different type of outreach.

Health coaches also make outreach calls to patients with chronic conditions who have been discharged from the hospital to make sure they understand their discharge instructions.

"We want to balance our resources appropriately and reach the members where we can have the biggest impact," Siejak says.

Low-risk members are those who fail to refill only one type of medication. They receive periodic automated telephone calls that include the program's telephone number if they want to contact a health coach with questions or concerns.

Members at moderate risk are those who fail to refill two or more medications. Automated telephone calls give them an opportunity to transfer directly to a health coach.

"The health coaches love the calls they get when the members make the choice to speak with them. This means that something in the automated call has hit home with them. They are primed and ready to make changes. It can be a much different response from what they get from many of the outbound calls to members," she says.

The automated calls include general information about the medication types the members are taking, why it is important to take it as prescribed, and what complications may occur if they don't.

"We always ask the member to verify his or her identify before the system launches into the

message," she says.

The automated calls encourage members to talk to a health coach or call their physician if they have any questions about their medication regimen.

"All of our interactions reinforce the members' relationship with their physician and encourage members to adhere to their treatment plan or talk to their doctor if they're having trouble with adherence," she says.

High-risk members receive an outbound telephone call from a health coach who educates the members about the importance of taking their medication and tries to engage them in health coaching to help them adhere to their physician's treatment plan.

Reasons the members give for not refilling their medication include side effects, forgetting to get it filled, and lack of information about why they are taking it.

Most members have a drug prescription plan, so cost is often not a factor, except in the case of Medicare beneficiaries who may have hit the donut hole in their prescription plan or who are having difficulties with copays.

"Sometimes when patients are prescribed a beta-blocker after a heart attack, they don't understand why they should continue taking it since they have completed cardiac rehabilitation and are feeling fine. They don't understand the risk in not taking it," Siejak says.

The health coaches discuss the individual issues with the member and emphasize the importance of taking the medications. They can also provide tools and resources to members to help them understand and keep track of their medications.

During the telephone call, the health coach works with the member to set goals for medication adherence and to develop strategies for meeting the goals.

They help the members prepare for a follow-up visit with their physician by discussing what questions the member should ask the doctor and what concerns they may want to bring up.

"The goal is to interact with the members and educate them to understand why it's important to adhere to their medication plan and to be an active partner with their physician," she says.

The health coaches work with the members to determine if they need follow-up calls and to set up a convenient time.

"The program is very member-centric. If the member seems to be doing well, the health coach may make only one telephone call. If someone is having a lot of problems, the health coach may call on a regular basis," Siejak says.

The health coaches, who are employed by a vendor with which Independence Blue Cross contracts, are health care professionals with 10 to 15 years experience. About 90% are registered nurses. The others are pharmacists, registered dieticians, and respiratory therapists who are called in when patients have specialized needs in their field.

The health plan conducts monthly data mining to identify members who are not filling their medication.

"We have checks and balance to monitor outreach efforts so the members don't get the same kind of calls over and over," she says.

In most cases, the same health coach works with the member but since the program is staffed by health coaches 24-7, if a member calls in the middle of the night or on the weekend, his or her health coach may not be at work.

The health coaches work on the same platform, which gives the coach who talks with the member the ability to access member information and leave information for the primary health coach.

"Greater than 80% of the time, the member talks to the same health coach," she says.

Since the medication persistence program was launched in July, 2009, the health plan has targeted 12,402 members with at least one automated outreach. About 90 of those members have been engaged in one-on-one health coaching. ■

Make business case for mental health interventions

'It's an investment in human capital'

If an employee is newly diagnosed with diabetes, he or she would likely be able to obtain a significant amount of resources for prevention, screening, and treatment of this condition. Would this also be true if that employee suffered from depression?

"The impact of employees who struggle with mental and substance abuse disorders is immense — and highly overlooked by employers," according to **Nancy W. Spangler**, MS, OTR/L, a consultant to the Partnership for Workplace Mental Health and president of Leawood, KS-based

Spangler Associates Inc. "These conditions have a tremendous impact on work attendance and performance, and they frequently contribute to disability."

A new study shows that effective treatment for employee mental health problems significantly improves productivity. [1] Researchers analyzed data on mental health symptoms, treatment, and productivity in more than 60,000 Australian employees. They found that with effective treatment, productivity of employees with mental health problems increased to levels near that of other employees.

"In general, the increase in employee performance outweighs the cost of treatment," says study author **Michael Hilton**, project director at the Queensland Centre for Mental Health Research in Australia. "Thus, employers should not see employee mental health services as a cost, but rather an investment in human capital."

Don't expect overnight results

You shouldn't expect employees who enter treatment for a mental disorder to become more productive right away. "It may take some time for the symptoms to remit due to treatment, and therefore, some time for productivity to increase," says Hilton.

Spangler says that occupational health professionals "can play a number of important roles to help employees dealing with emotional issues and mental disorders." Take these steps:

• **Make the financial connection**.

"Share resources with executives that help explain the human and financial costs of mental illness in the workplace," says Spangler.

• **Improve awareness about mental disorders.**

One way of doing this is to include questions about stress and depression in health risk appraisals. "Develop strategies for following up with those people who are at risk, such as print information or phone calls," says Spangler.

Managers may need training in order to recognize employees in distress, and then, refer them to mental health resources through your health plan or community. "Help them understand the fine line between respecting employee privacy and ignoring pleas for help," says Spangler.

• **Prevent stress and strain that can trigger disorders.**

Spangler recommends partnering with other departments, such as human resources, employee assistance, health promotion, safety, and disability management to identify overlapping physical and mental conditions. "Create stress-reducing environments and practices, such as areas for quiet relaxation and flexible scheduling," she says. "Offer programs in building resilience and coping skills, such as yoga, meditation, Tai Chi, and relaxation."

• **Help employees who do go out on behavioral health-related disability return to work successfully.**

"Work with managers to set return-to-work dates for those out on disability leave. Help build employee confidence about returning to their role," says Spangler. "Or, work with management to find an alternative placement that helps the employee return more successfully."

Reference

1. Hilton MF, Scuffham PA, Sheridan JD, et al. The association between mental disorders and productivity in treated and untreated employees. *J Occup Environ Med*. 2009; 51(9):996-1003. ■

Screen employees for depression, anxiety

Since employees with medical conditions such as diabetes, heart disease, and cancer often have co-morbid mental conditions, it makes sense to screen these workers for depression, says **Nancy W. Spangler**, MS, OTR/L, a consultant to the Partnership for Workplace Mental Health and president of Leawood, KS-based Spangler Associates Inc. "Screen for depression in diabetes management programs, for example," she says. "Treating the underlying mental condition helps reduce the costs of the medical treatment."

If you do screen for depression or anxiety when workers come to see you for other issues, "provide mental health information, and make appropriate referrals to employee assistance programs or community services," says Spangler.

At Polk County in Bartow, FL, the occupational health clinic uses the Patient Health Questionnaire Nine-Symptom Checklist to screen employees. If mental health issues are identified, a referral is made to the employee assistance program and to the worker's primary care physician.

"By doing the depression scale, we expect to remove obstacles to treatment of many chronic

diseases, such as diabetes and hypertension," says **Mike Kushner**, the county's risk management director.

Employees who have depression may not be able to adhere to their medications or may not obtain optimal results. "Our disease management program also takes note of family issues, financial issues, and other factors, which may lead to depression and or anxiety," says Kushner.

Clinical outcome reports are shared with senior management, including data from the county's employee assistance program, which shows relatively high utilization compared to norms.

"We expect that this is due to a high number of referrals. Many of our members have co-morbidities, including depression, which have an impact on the overall outcome," says Kushner. "We have confidential data, which show that patients who do receive mental health treatment have better outcomes in terms of their overall disease management goals." ■

If a worker is badly injured, what happens next?

It's a moment dreaded by every occupational health manager — learning that an employee was seriously injured at work. It's also the "moment of truth" for how well the occupational health manager does his or her job.

According to **Mary (Penny) B. Nicholls**, RN, CCM, COHN-S, a disability consultant with Alabama Power Company in Birmingham and a member of the advisory board for the Deep South Center for Occupational Health & Safety at the University of Alabama at Birmingham, if a worker is badly injured, the first thing that should be done should be to assess the severity of the injury. Direct the employee's care to a medical facility that can provide the appropriate level of care needed.

"If it is a burn, don't waste critical minutes by sending them to a tertiary hospital," says Nicholls. "Get them to the nearest burn center, by air evacuation if possible. Or if it is a major trauma, direct them to the nearest Trauma Center."

Robert Emery, DrPH, vice president of safety, health, environment and risk management at The University of Texas Health Science Center at Houston, says that your first step — after ensuring prompt, compassionate care for the employee — is to address other needs of the injured worker. These include family notifications and assisting with the filing of worker's compensation insurance claims.

"Ensure that the hazard that caused the injury is mitigated in some way, even if it's with something like temporary barriers," he says. "Review OSHA [Occupational Safety and Health Administration] reporting requirements to determine if the event meets the threshold for immediate notifications, or if it is merely to be recorded on the OSHA 300 log."

Begin investigation

Delegate someone onsite to begin a thorough investigation into the accident, and do this quickly and effectively, says Nicholls. Take these steps:

• Identify witnesses and separate them to gather statements.

Have each person write down what he or she witnessed. Read it and ask questions that clarify their description of the injured employee, what they were doing, and the environment at the time of the accident.

"Each witness saw the incident through a different set of eyes, but can be easily swayed by coworkers telling what they thought they saw at the time," says Nicholls.

• Get photographs as soon as possible of the accident area.

"Many cases may not go to court for years," says Nicholls. "Everyone's memory either fades with time, or becomes clearer based on the information they hear from others at the scene."

• Cover the "5 W's" — who, what, when, where, and why.

Document what processes/actions were being performed at the time; what procedures were being followed; whether personal protective equipment was in place or not, and if it was required for the process being performed; and machinery lock-out status. Identify anything that was different on the day of the injury from the other days the process has been performed without injury, says Nicholls.

The person who accompanies the employee to the hospital must be made aware of the need to salvage all of the clothing, including any personal protective equipment the injured employee may be wearing, and gather it for the safety department, says Nicholls.

Your documentation should include witness statements, photographs, and diagrams of the accident location and all of the surrounding areas. "No clothing, personal protective equipment or tools should be destroyed. They should be bagged and preserved until released by the Safety Team, as they may be vital to the investigation," says Nicholls. ■

Never do these things after a worksite injury

Avoid trouble with the Occupational Safety and Health Administration (OSHA) by never doing any of the following things after a worksite injury occurs, warns **Mary (Penny) B. Nicholls**, RN, CCM, COHN-S, a disability consultant with Alabama Power Company in Birmingham and a member of the advisory board for the Deep South Center for Occupational Health & Safety at the University of Alabama at Birmingham:

1. Taking any steps that would contaminate the accident site, such as removal of machinery or equipment, especially if a fatality has occurred.
2. Instructing employees not to discuss the event with OSHA inspectors. "This is not allowed by law. Do not threaten to punish an employee for speaking with OSHA inspectors," says Nicholls. "This is a protected right."
3. Falsifying documents at any time during the investigation, including witness statements. ■

Get workers to commit to short bouts of exercise

Getting employees to commit to hour-long workouts at the gym might be expecting the impossible in many cases. However, new research shows that short bouts of exercise also have significant benefits.[1]

Researchers studied 2,364 workers and found that "active commuters" — those who walk or ride a bike to work at least part of the way to work — performed better on a fitness test than those who drive or take public transportation.

"It would be great if more communities made it easier for people to work activity into their lives by, for instance, building more sidewalks and bike lanes, and for more workplaces to provide bike parking, showering, and changing facilities," says **Penny Gordon-Larsen**, PhD, the study's author and a nutrition associate professor at University of North Carolina's Gillings School of Global Public Health in Chapel Hill. Here are three low-cost ways to get employees moving for short periods during the day:

• Hold "walk and talks" instead of sit-down meetings.

"Instead of meeting at a table, grab your shoes and walk and talk instead of sitting and talking," suggests Gordon-Larsen. "This works less well with a large group. But for smaller groups, it's a great way to sneak in a bit of exercise."

• Make taking the stairs more appealing.

"Play music only in the stairways, not in the elevators, with a different decade every week — the 1970s, 1980s, 1990s, 2000s," says **Margie Matsui**, BSN RN CRRN COHN-S FAAOHN, programs administrator for central health services at Northrop Grumman in Redondo Beach, CA. For fall protection, make sure that the stairwell lighting is good and there are no spills or liquids, she warns.

• Catherine Rausch, MN, RN, senior occupational health nurse at Marathon Petroleum Company's St. Paul Park, MN, refinery, says that taking the stairs has become part of her company's culture. "If you are talking with someone and they use the stairs, then you will go along, too. Soon it becomes the way to get from 1 to 2," says Rausch. "We have posters at the top and bottom reminding people to use the handrails."

• Give employees bikes to use.

In the warmer weather, bikes are placed in strategically located racks around Marathon's large plant, labeled for each area and department. "Organized riding would not work, since breaks are generally very flexible and employees don't have set times. But some of the folks will ride around together at night, just to get some exercise," says Rausch.

If someone from the loading area needs to go to the administration building, they grab a bike from the rack and return it to another rack by that location. When they want to go back, they ride it back down.

Rausch encourages the activity by riding herself. "My bike is a red adult tricycle, so I have a big basket between the back wheels to carry my first aid bag and AED if I need them. The basket in the back is large and more stable than trying to have a big basket on the front." ■

Don't ignore the health impact of job insecurity

These days, many workers have a high amount of anxiety over job security, with good reason. Now, a new study shows this poses a major threat to worker health.

Researchers analyzed data on more than 1,700 adults collected over periods from three to 10 years, to determine if there was any link between poor health and job security. They found that in fact, worrying over job loss was strongly linked to health declines, even more so than actual job loss or unemployment.[1]

Study author **Sarah Burgard**, PhD, an assistant professor at the University of Michigan Institute for Social Research in Ann Arbor, says that at first, she was surprised by the study's findings. "I started working on this with the expectation that the link between perceived job insecurity and subsequent health would be accounted for by the effects of actual job losses that some people worried about job loss were correctly forecasting," she says. "But, we found that people who were persistently concerned about losing their jobs reported significantly worse overall health in both studies. In one of the studies, they were more depressed than those who had actually lost and regained their jobs recently."

However, Burgard says that after some reflection, it made sense that persistent insecurity could lead to poor health. This could be due to ongoing uncertainty about the future, the inability to take action unless the feared event actually happens, and lack of institutionalized supports for perceived job insecurity.

"When you consider that not only income but so many of the important benefits that give Americans some peace of mind — including health insurance and retirement benefits — are tied to employment for most people, it's understandable that persistent job insecurity is so stressful," says Burgard.

To counter this tendency, Burgard says that communication is key. "Increasing information so that employees can make plans could be very helpful," she says. "Keeping people in the dark will increase negative water cooler chatter, lower the productivity of stressed workers, and may hurt the bottom line."

Reference

1. Burgard S, Brand J, House JS. Perceived job insecurity and worker health in the United States. *Soc Sci Med* 2009; 69(5):777-785. ■

COMING IN FUTURE MONTHS

- Dealing with the obesity epidemic
- Case management through the continuum
- Ways to prevent hospital readmissions
- Integrating CM, DM, and health coaching

CE questions

1. The Case Management Model Act is not a bill, but rather a document that educates legislators and regulators.
   A. True
   B. False

2. The Independence Blue Cross Connections Health Management Program includes members with which chronic conditions?
   A. coronary artery disease
   B. heart failure
   C. diabetes
   D. all of the above

3. Which is true regarding employees with mental health disorders?
   A. Treatment for employee mental health problems has no impact on productivity.
   B. With effective treatment, productivity of employees with mental health problems increased to levels near that of other employees.
   C. If employees who enter treatment for a mental disorder fail to become more productive right away, they're unlikely to improve at a later point in time.
   D. Questions about stress and depression should not be included in health risk appraisals.

4. Which is recommended regarding actions to take after a workplace injury occurs?
   A. The hazard that caused the injury should not be mitigated with temporary measures.
   B. Witnesses should not be asked questions about the environment at the time of the accident.
   C. Photographs of the accident area should not be taken.
   D. No steps should be taken that would contaminate the accident site, such as removal of machinery or equipment.

Answers: 1. A; 2. D; 3. B; 4. 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 the clinical, legal, legislative, regulatory, financial, and social issues relevant to case management affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities. ■

CE instructions

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

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

Hours, responsibilities increase for case managers

More practice settings want coverage seven days a week

Case managers are more experienced and are putting in longer hours than ever before, but aren't necessarily getting more compensation for it, according to the results of the 2009 *Case Management Advisor* Salary Survey.

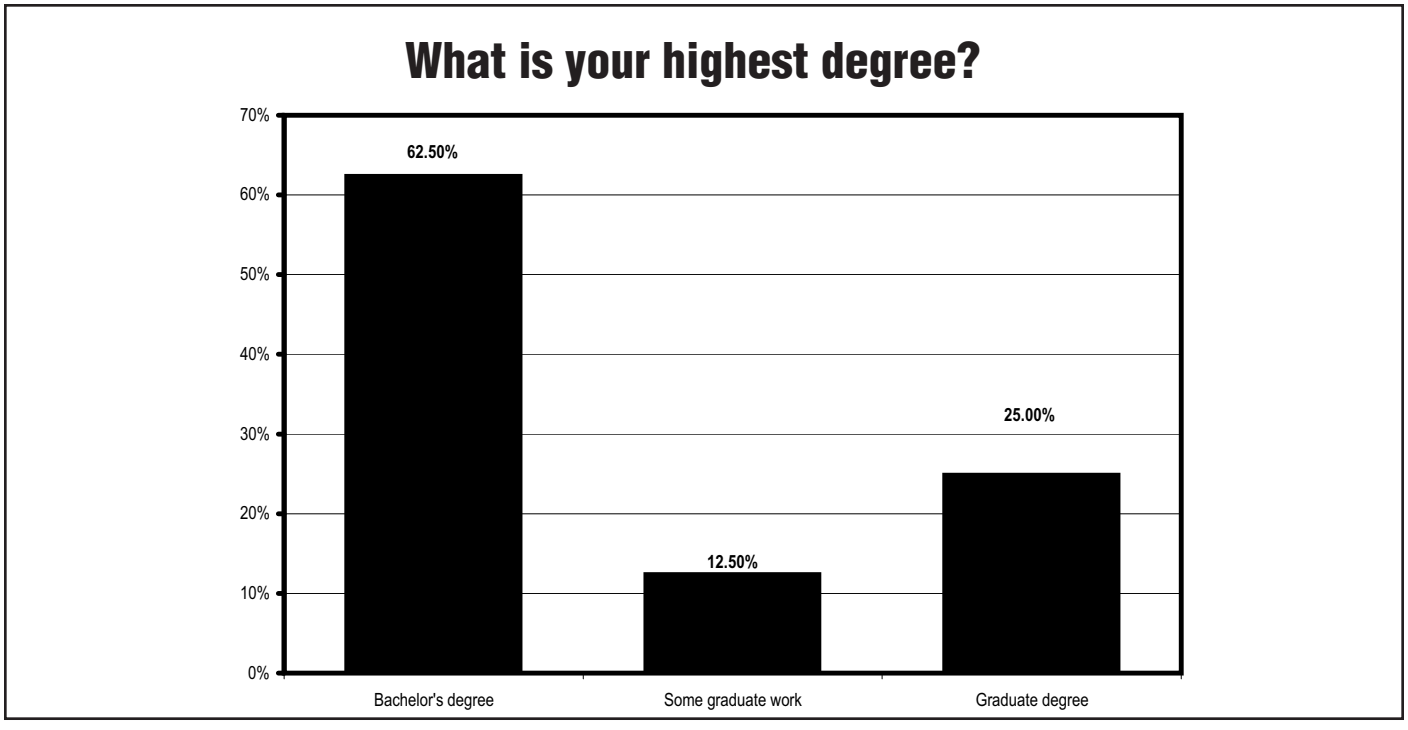
The 2009 salary survey was mailed to readers of *Case Management Advisor* in the June 2009 issue.

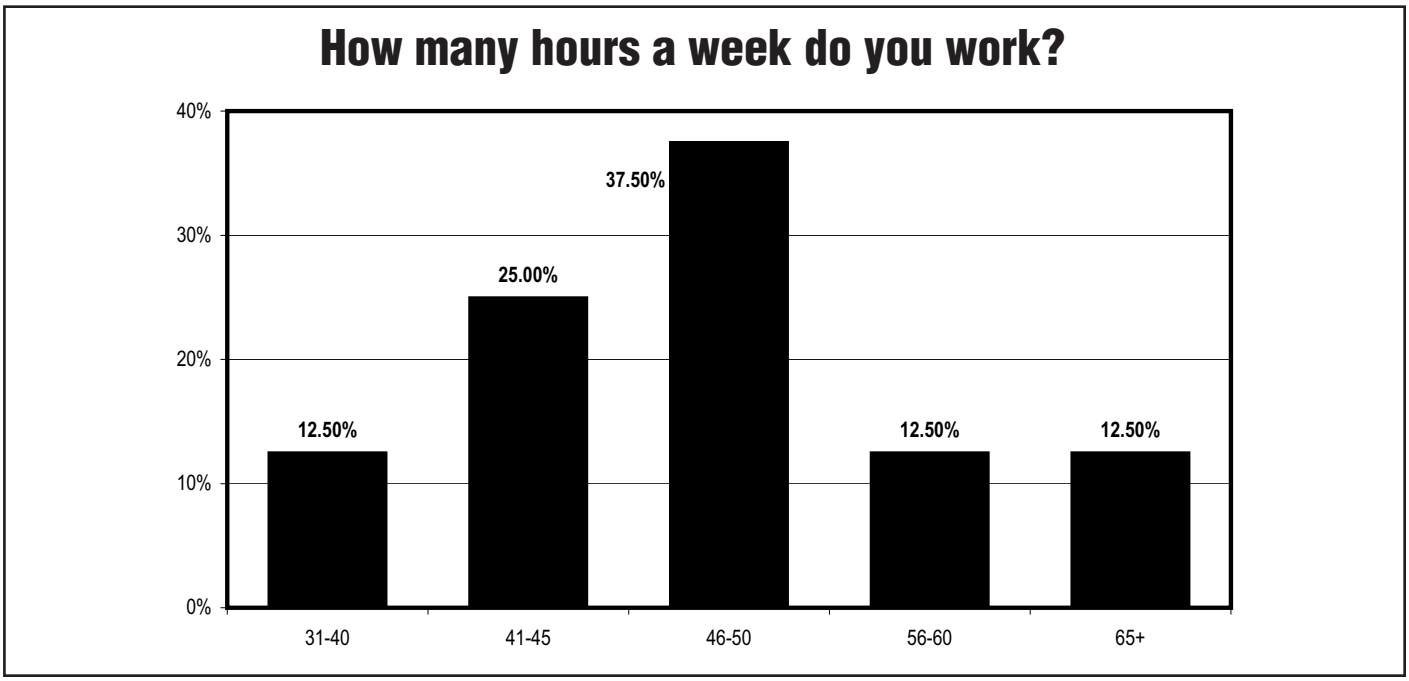
The majority of the respondents (75%) were case management supervisors or directors and 12.5% were case managers. The rest held other positions.

More than a third of the respondents (37.5%) reported that they received no salary increase last year. Another 37.5% reported raises of 1% to 3%, and 25% received a raise of 4% to 6%.

At the same time, respondents to the survey reported putting in long hours. The vast majority of respondents to the survey (87.5%) reported working more than 40 hours a week, with more than 25% reporting working 56 hours or more.

Case managers who responded to the survey are older and experienced, with 75% reporting 22





years or more experience in the health care field and 62.5% who have been a case manager 10 years or longer. Only 12.5% of respondents reported being under 41 years old.

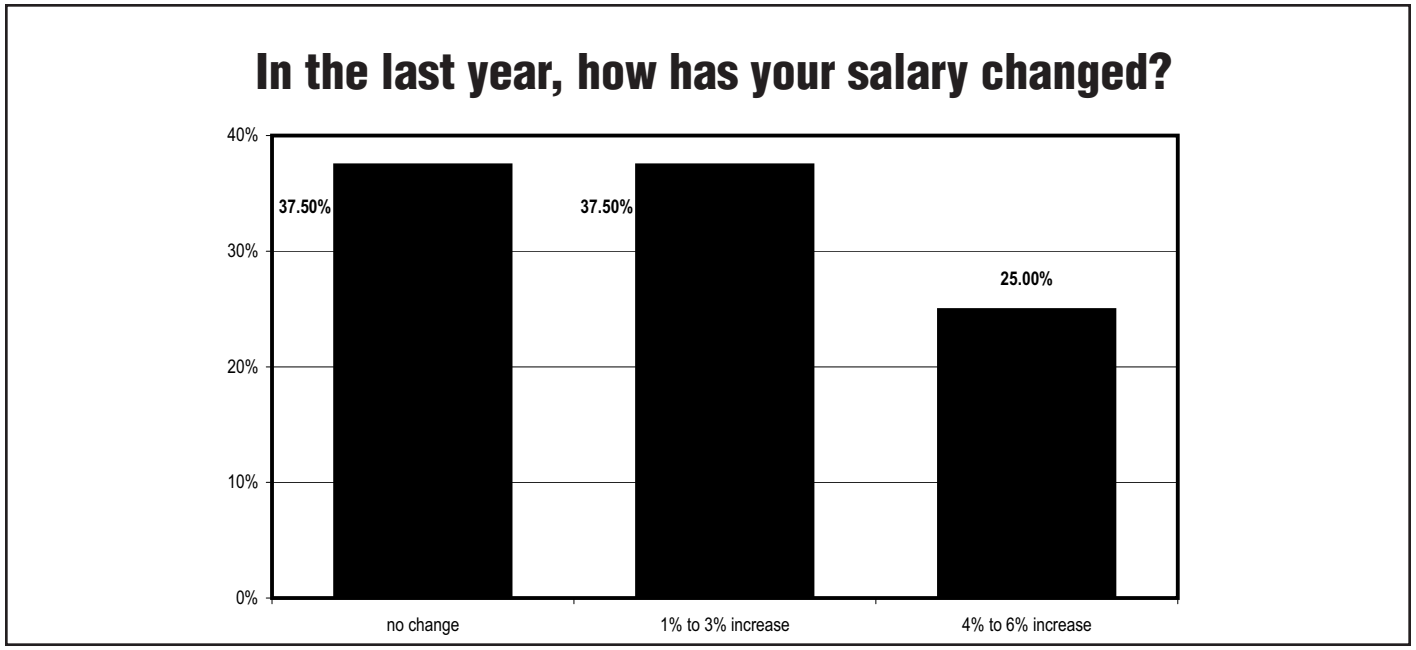
While their responsibilities are increasing, staffing in case management departments seems to be staying stable. While 25% of respondents reported that their staff had decreased, 37.5% reported an increase in staff, and the same percentage reported that their staff stayed the same.

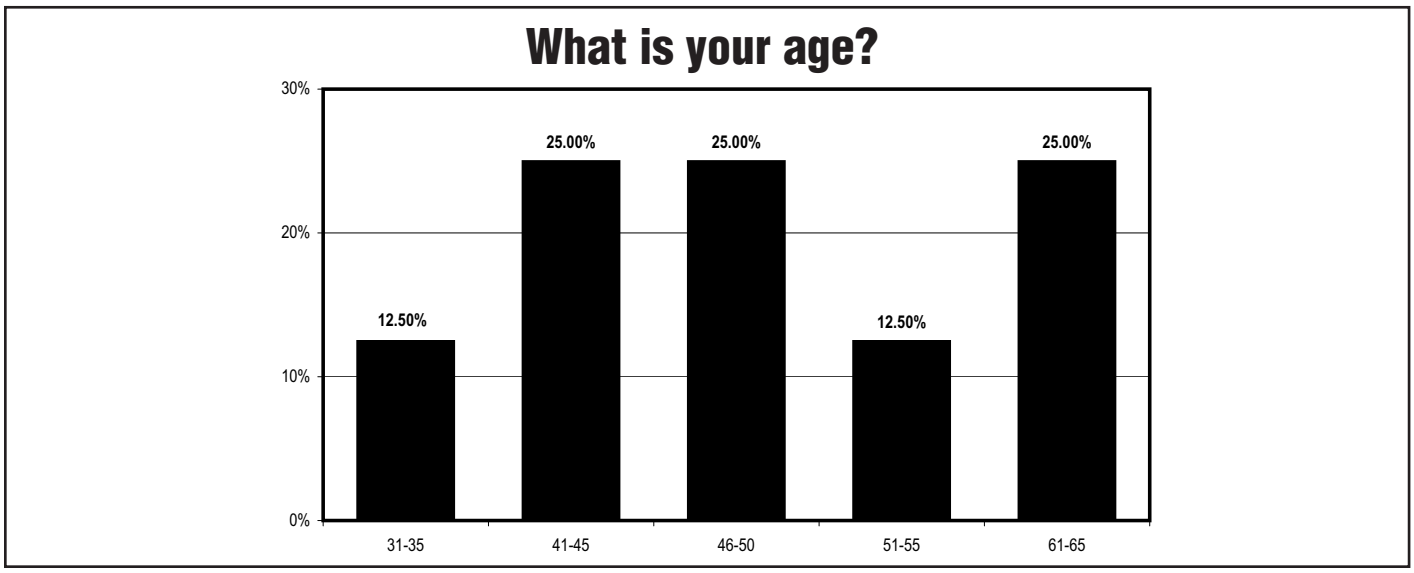
For the first time in many years, the nursing shortage doesn't seem to be impacting case management hiring, says **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president and founder of Mullahy & Associates, a case management training and consulting company.

In fact, she reports that a nurse recruiter told her that she has as many as 250 applicants for every two positions.

As the Case Management Society of America contact for her area, **B.K. Kizziar**, RN-BC, CCM, CLP, frequently gets e-mails from recruiters with positions to fill. However, they are all management positions at the corporate or director level, she says.

"We're not doing very much to mentor new and





younger people into case management. This could be a big problem in the future," says Kizziar, owner of B.K. & Associates, a Southlake, TX, case management consulting firm.

Kizziar says that a fellow case manager who works at a health plan reports that her department has two vacancies.

"They've opened up these positions for a few days, then closed them again. They are waiting to see what will happen with health care reform," she says.

Some nurses go into case management thinking it's one thing and then find out that it's something else, Mullahy reports.

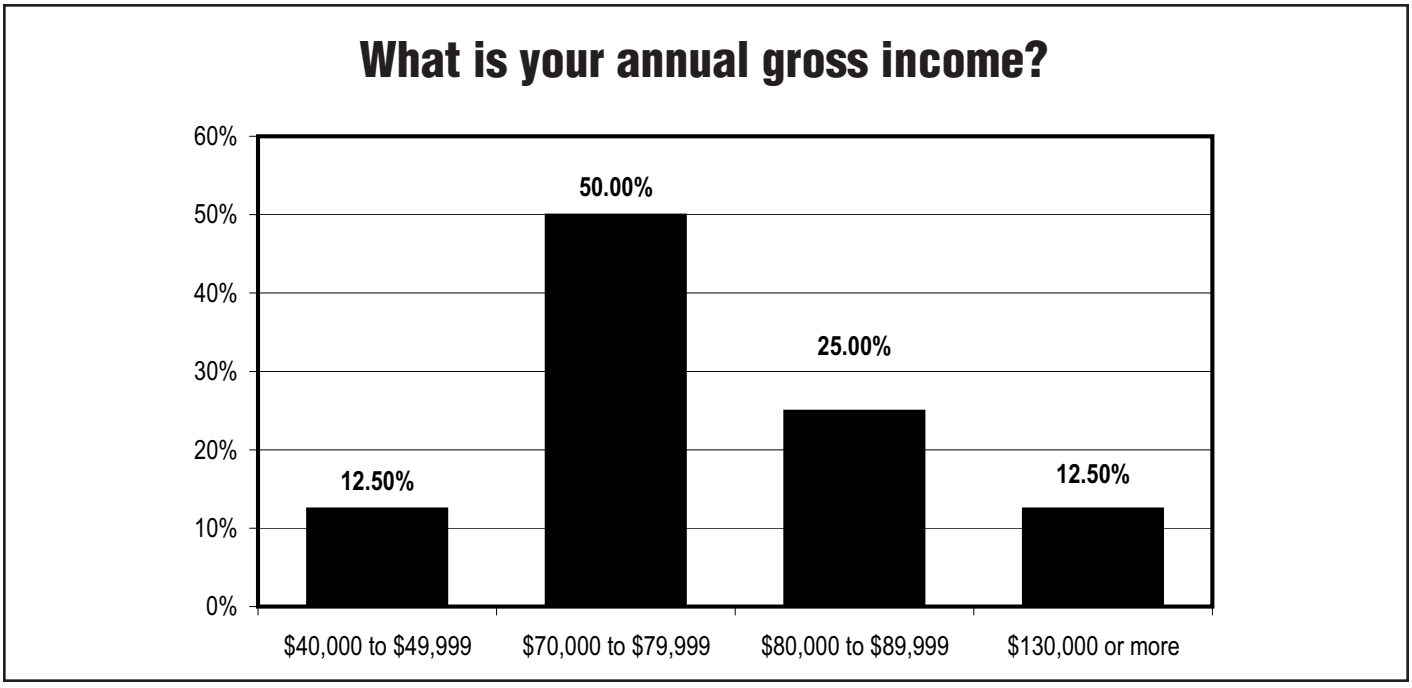
They're working longer hours and spending more time on paperwork than interacting with patients, she adds.

At one time hospitals were able to capitalize on the fact that case managers work regular business hours Monday through Friday, she points out.

"Now, because of pressure from payers, hospitals are staffing their emergency department and other areas of the hospital seven days a week and sometimes 24 hours a day. They often have case managers coming in on weekends to handle discharges," Mullahy says.

At the same time, insurers have extended the hours of their nurse triage lines and disease management nurses to be more accessible to members, she adds.

"Case management in many settings is no longer a Monday-through-Friday, 9 am to 5 pm position. If the chronically ill people are still working, someone needs to call them in the evening



when they're at home. There is an increasing need for evening and weekend staffing," Kizziar adds.

Hospitals are extending the hours of case managers, particularly in the emergency department.

"Those of us who are experienced tend to feel like we've already paid our dues by working weekends and holidays when we were floor nurses," Kizzier says.

The majority of health plan positions are still Monday through Friday, Kizziar adds.

"Health plans are still safe havens for those who want to work regular hours," she says.

In addition, many health plans offer better benefits than hospitals, she adds.

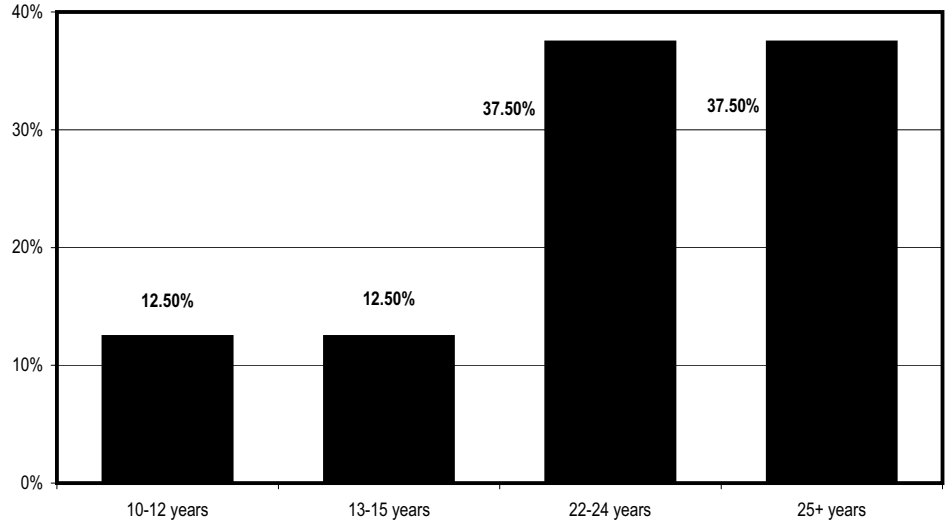
"Particularly as they mature, more and more people are looking for better benefits rather than higher salaries," she says.

Hudson Health Plan in Tarryton, NY, offers a benefit package that includes paying for case managers to join the Case Management Society of America (CMSA) and their local chapter, says **Margaret Leonard**, MS, RN-B-C, FNP, senior vice president for clinical services at Hudson Health Plan and president of CMSA.

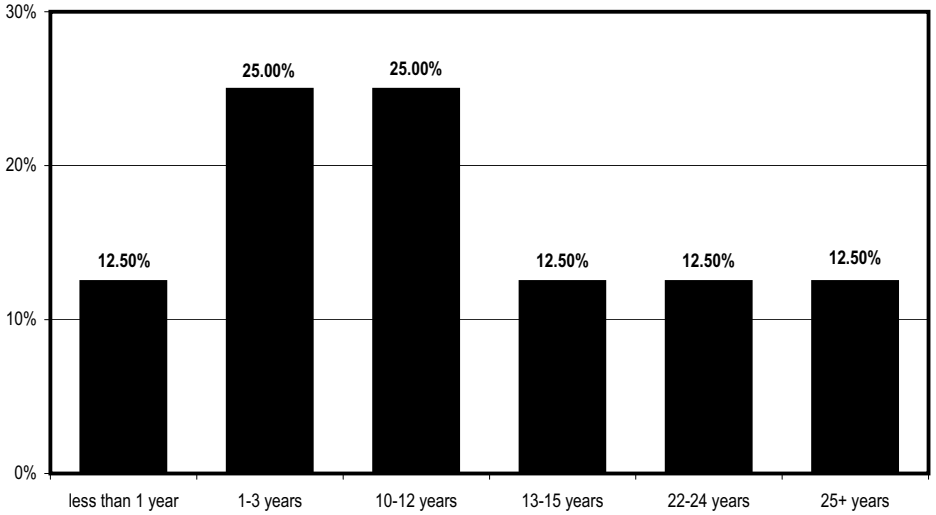
In addition, the health plan pays for case managers to take a review course and to sit for the certification exam. Case managers who become certified receive a $3,000 bump in salary.

"I hope more and more employers will start to value case management certification and increase the salary for case managers who become certified," she says. ■

How long have you worked in health care?



How long have you worked in your present field?



AHC Media LLC

AHC Media's Message to Subscribers about Copyright Law

Your newsletter is a copyrighted publication. It is protected under federal copyright law.

It is against the law to reproduce your newsletter in any form without the written consent of AHC Media's publisher. Prohibited under copyright law is:

- making "extra" copies of our publication for distribution in your office;
- posting newsletter articles on your facility or practice web site;
- downloading material to an electronic network;
- photocopying, e-mailing, or faxing newsletter articles.

Site licenses, which allow you to e-mail, fax, photocopy, or post electronic versions of your newsletter and allow additional users to access the newsletter online, are available for facilities or companies seeking wider distribution of your newsletter.

High-quality reprints of articles also are available at reasonable prices.

To get information about site license or multiple copy arrangements, contact Tria Kreutzer at (800) 688-2421, ext. 5482 (tria.kreutzer@ahcmedia.com); or for reprints, contact Steve Vance at (800) 688-2421, ext. 5511 (stephen.vance@ahcmedia.com).

Thank you for your cooperation,

Donald R. Johnston
Senior Vice President/Group Publisher
AHC Media LLC

N #4005

3525 Piedmont Road NE
Building Six, Suite 400
Atlanta, Georgia 30305-1515
Tel (404) 262-7436
Fax (404) 262-7837
www.ahcmedia.com