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Covering Case Management Across The Entire Care Continuum

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IN THIS ISSUE

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Blended care management model cuts costs for high-risk Medicaid members

Health plan takes holistic approach to meeting patient needs

A blended model of care management has decreased hospitalizations and emergency department visits and cut medical expenses for high-risk Medicaid recipients with Keystone Mercy Health Plan.

"Since we began this program in 2004, we have had the results analyzed by three outside entities as well as looking at them internally. All have shown a definite cost savings," says **Karen Michaels**, RN, MSN, MBA, vice president of clinical services for the Philadelphia-based health plan, which is a member of the AmeriHealth Mercy Family of Companies.

The blended model encompasses care management, health interventions, member-centric care plans, and a coordinated outreach approach and is tailored to help meet the challenges in providing services to Medicaid beneficiaries, Michael says.

Medicaid members have so many challenges in their lives that taking care of medical conditions and working on improving their health may not be a high priority. Instead, they are more focused on issues such as how to get the rent paid or getting the electricity turned back on, and often have little energy or time to devote to handling their medical issues, she adds.

"One of the main challenges with the Medicaid population is that this membership is very fluid. They aren't in one location for a long period of time; their contact information changes often. Just locating them and staying in touch is a challenge," Michaels says.

The program blends the areas of disease management and case management into a care management program, says **Lynne Harsha**, assistant vice president for PerforMED operations at the health plan.

"We have combined specific elements of our chronic condition management program and care coordination capabilities with our member advocacy approach to create a unique, intensive care management

program. When we contact the members, we don't just talk about their diabetes or heart failure. We discuss what else is going on in their lives and focus on addressing the most urgent health-related issues while also considering what the members consider to be their most immediate concern," she says.

The program isn't limited to helping members manage their physical health, Harsha adds.

"The blended model also includes a behavioral health component that connects the members to the resources and care they need to manage their overall health in a holistic, member-centric fashion," she says.

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The health plan's high-risk Medicaid members have a high instance of behavioral health issues, including depression and bipolar disorder, Michaels adds.

"A lot of medical management models include just disease management based on an illness or just case management or a stand-alone program for smoking or weight loss. Our blended model integrates all of those services, and our rapid response and outreach team ensures that there are no fragmented points of contact," Michaels says.

Rapid response and outreach team staff handle inbound calls from providers, community agencies, and members and work with those members who need help on a short-term basis.

"In our unique model, the member services department refers members to the rapid response unit for help with issues around health or social support even if they aren't necessarily a candidate for long-term case management or disease management or our blended model," Harsha says.

For instance, a member may have a broken wheelchair and need to get it repaired. Someone else may have lost his or her prescription and need support in calling a physician for a new copy.

The rapid response and outreach team helps members with their immediate problems and follows them to make sure they are stabilized before they close the case. They leverage their knowledge of community-based programs and help members connect with other resources.

"They work with all of the departments at Keystone Mercy and understand what services are provided and how to advocate for the members to deal with any kind of issue," Harsha says.

The majority of members in the high-risk program are identified through an analysis of claims and pharmacy data using an algorithm that predicts future health care utilization as well as severity of chronic illness.

Members who are the sickest or most likely to have future health care needs are targeted for the program.

The plan also receives referrals from physicians as well as self-referrals from members.

Other members eligible for the program are identified by a health risk assessment given to all new members by the utilization management staff, which handles authorization for services and medical necessity and refers cases when they identify a situation that needs care management.

Once members are identified as eligible for the

high-risk program, the health plan tries to reach them by telephone. If their number has changed, the team contacts the physician or pharmacist to get a correct phone number.

In some markets, the health plan sends its community outreach solutions "street team" to the home to make contact with the member.

The "street team" staff are lay people who are trained and equipped to conduct outreach. Many of them are hired through the Welfare-to-Work program and come from the same community as the members. Others may be Medicaid recipients themselves.

The program takes a team approach to coordination of care. The team includes the care manager, either an RN or a social worker depending on the needs of the member, a case management technician, the member's primary care physician, the member, and his or her family members.

Most of the case management technicians have a medical background and customer service experience. They are trained in medical terminology, customer service, patient advocacy, and resources in the community and assist the care manager in helping members access services such as food banks, pharmacy assistance, and transportation.

"The care manager and the case management technician work as a team. This arrangement maximizes the time for the care managers, allowing them to focus on matters that need their clinical expertise," Harsha says.

Once the care manager connects with the members, he or she starts the assessment process. The care managers have access to screens that show claims data, physician and emergency department visits, prescriptions, and hospitalizations.

"They find out what the members know about their medical conditions and medications and compare it with what we have in our system. They ask about their living situation and screen for depression," Michael says.

The care managers begin by establishing a relationship with members, identifying their priorities and finding goals that are meaningful to them. For instance, when a member has heart failure and needs to maintain his or her fluid balance and lose weight, the care manager won't focus on weight loss but might work with the member to establish a goal of being able to walk around the mall with her children.

"As we collect that information, we start to generate a care plan. We identify potential areas we want to work on and set goals for the benefit of the member, and not just their health status," she says.

The care managers contact the members' primary care physician and collect information from the office as well as finding out any gaps in information that the physician may need.

The care manager sends a summary of the care plan to the member and to the physician.

The health plan's electronic system automatically creates tasks in the care plan for each of the team members.

For instance, the care manager may ask the case management technician to arrange an appointment with a physician or set up transportation for a test or procedure.

Once the care plan has been established, the case manager sets up the tasks and follows up with the member, providing education, general support, and education.

"The care plan is an ever-changing one. Sometimes, down the road, members have other needs, such as experiencing fluid retention, problems ambulating, or needing food; we continuously re-evaluate the members' priorities and ensure that they have the resources they need," she says.

The care managers work on each member's individual issues, help the members work through the barriers to adherence, and keep them focused on steps they can take to improve their health, Michaels says.

In the beginning, the care manager may contact the member every day and gradually taper off as the member's needs stabilize.

"Our goal is to get enough assistance to support the member's ability to self-manage his or her conditions. As the member becomes more independent, the care manager decreases frequency of contact to every one to three months, checking on follow-up appointments and making sure the member's needs are being met," she says.

Some members get to the point where they don't need assistance and the case manager closes the case, Harsha says.

"We have a large group of members in this program, such as those with heart failure and diabetes, whose needs will be ongoing. We keep these cases open indefinitely," she adds.

The vast majority of contacts between the member and the case manager are by telephone.

"On occasion, a case manager will meet a member who needs special consideration in the home or a provider office," Harsha says.

Members are assigned a nurse or social worker

care manager depending on their needs. The social work care managers work with members who have intense behavioral health issues and fewer medical issues.

"The two disciplines have rounds where they talk about cases that are challenging. They consult each other frequently and work as a team," she says.

Some of the staff work from home but are in touch by telephone and e-mail.

The health plan holds care management rounds every two weeks. During the rounds, staff members present challenging cases and the team brainstorms strategies and solutions.

"It's an open and sharing session. We take turns presenting cases, and the team shares their experiences with similar cases and strategies that have worked. The whole staff learn from this approach," Harsha says. ■

Plan targets those at risk for cardiometabolic syndrome

Aim to get members on the path to healthier lifestyles

As part of its focus on prevention as a successful strategy to improve the quality and lower the cost of health care, Independence Blue Cross has launched a program targeting members who are at risk for cardiometabolic syndrome, a condition that may increase a person's chance of developing heart disease and diabetes.

The cardiometabolic risk management program is part of Independence Blue Cross' Connections Health Management Program.

"Chronic conditions, such as heart disease and diabetes, are very costly, not only to those who have them, but to all of us. These diseases may be preventable and are treatable. We strive to help our members get on the path to healthier lifestyles now, in the hopes that they will lessen their chances of developing, or worsening, serious and costly health conditions," says **Esther Nash**, MD, senior medical director for Independence Blue Cross.

The American Heart Association estimates that more than 50 million Americans have cardiometabolic syndrome.

"Cardiometabolic syndrome is not necessarily a disease or a condition but a constellation of risk factors that put people at risk for developing heart disease and Type 2 diabetes," says **Kimberly Siejak**, manager of population health and wellness for the Philadelphia-based health plan.

Risk factors that increase a person's overall chance of developing heart disease and diabetes include tobacco use, high body mass index, obesity, hypertension, high cholesterol, high levels of triglycerides, and elevated blood sugar levels, she adds.

"This program is different from a lot of disease management and health coaching programs because our goal is to prevent members from developing a disease. The program identifies people who may not have received a diagnosis of the disease but they are heading that way because of their lifestyle habits," she says.

The program provides education that is designed to help members avoid developing heart disease and diabetes.

The program identifies members at risk through medical and pharmacy claims data as well as the results of the health plan's health risk assessment.

The health plan uses a series of proprietary algorithms to stratify members and to identify those who are at highest risk.

For instance, to identify members with hypertension who are at risk, the health plan uses a combination of factors including hospital and emergency department visits and whether the member has filled his or her prescriptions.

The purpose of the program is to educate members about the symptoms of heart disease and diabetes and the behavior and lifestyle changes that may help prevent the diseases, Siejak says.

The program is staffed by health coaches who have an average of 10 to 15 years of clinical experience and are trained to help people manage their chronic conditions and assess readiness to change.

Low-risk members receive automated outreach calls that give them the option of contacting a health coach and enrolling in the program.

High-risk members receive telephone calls from health coaches who describe the program and invite them to participate.

The health coaches assess the members' readiness to change and work with them to develop strategies to modify their lifestyle.

Since many of the people who are at risk for developing metabolic syndrome lead sedentary lives, the coaches work with them to increase their physical activity.

They coach members to adopt healthy eating

habits and to reduce their intake of fat.

"Once members engage with the health coach, they are invited to participate in behavioral change programs, depending on their type of risk. We have a program for tobacco cessation and an intensive weight management program," Siejak says.

The coaches help the members make lifestyle changes that can lower their risk. For instance, they may work with people with hypertension on cutting down on the salt in their diets and educate them on which foods to avoid.

Members who are working with the health coaches receive tool kits of exercises they need to complete between the health coach sessions.

For instance, in one exercise that is part of the smoking cessation program, the member keeps a log of triggers for smoking and in another is asked to tally the number of times he or she has tried to quit smoking in the past.

"The health coaches make follow-up calls and discuss the exercises with the member. This coordinated learning experience that combines what they are doing with the tool kit and the session with the health coach enables members to get a better handle on what motivates them to smoke and work with the coach to come up with a plan to change their behavior," she says. ■

Tailoring DM to patient improves outcomes

Study shows reduced hospitalizations, ED visits

People with chronic conditions who received telephonic disease management coaching based on their level of health activation had fewer visits to the hospital and emergency department than people coached in the usual way, a study has shown.

The study, conducted by **Judith Hibbard**, PhD, and her colleagues at the University of Oregon, compared the behavior of individuals receiving standard telephonic disease management coaching with that of those who received more tailored coaching based on their "activation level." The study was funded by the Health Industry Forum at Brandeis University.

Hibbard is a professor of health policy in the department of planning, public policy, and management at the University of Oregon and a clinical professor in the department of public health and preventative medicine at Oregon Health and Sciences University.

A patient's activation level is determined based on his or her responses to the Patient Activation Measure (PAM), a tool developed by Hibbard and her colleagues, which measures a person's knowledge, skills, and confidence in playing a role in his or her own health care.

Participants in the study who received the tailored coaching showed a 33% decline in hospital admissions compared to the control group, resulting in an average savings of $145 per person per month.

The group receiving the tailored intervention also had a 22% decline in emergency department visits compared with the control group, for an average savings of $11 per person per month. Among participants in the control group, hospital admissions remained flat for patients in the control group. Emergency department visits for the control group increased by 20%.

The group that received tailored coaching experienced significant improvements in diastolic blood pressure and LDL cholesterol levels compared to the control group and increased their adherence to recommended immunization and drug regimens.

The study was conducted at two call centers staffed by RN health coaches.

The call centers were selected based on the similarity of the nurse coaches' tenure and years of experience.

The nurse coaches were trained on coaching skills and how to administer the PAM tool.

At one of the centers, the researchers trained the coaches on how to use the tool to tailor their coaching to each individual. The nurses at the other center, who worked with the control group, were just told to administer the PAM tool at least twice during the six months of the study period.

The team analyzed the gains in the PAM score, adherence to the treatment plan, clinical indicators such as LDL cholesterol and blood pressure, and utilization.

"The results showed that coaching to the patient's activation level was more effective in every measured considered, whether it was clinical indicators, clinical outcomes, cost, or utilization," says **Mary Jane Osmick**, MD, vice president and medical director for LifeMasters Supported SelfCare Inc., an Irvine, CA-based provider of health improvement and condition management programs and services, which oper-

ates the call centers.

The Patient Activation Measure includes a series of questions that focus on the role the person plays in his or her own health care. Patients answer the questions on a scale that ranges from "strongly disagree" to "strongly agree."

One question asks if the patients know what medication they are on and how to take them. Another asks if they know how to take care of themselves when they get sick.

"Each question focuses on a specific area where people fall down or are very good at being an advocate for themselves," Osmick says.

Based on responses to the questions, each person is assigned an "activation score" ranging from one to 100, with most people falling in the 35 to 85 range, Hibbard says.

"Research suggests that people pass through four different levels of activation on their way to becoming effective self-managers," Hibbard says.

Patients on Level 1 tend to be overwhelmed and unprepared to play an active role in their own health. Patients on Level 2 lack the knowledge and confidence for self-management. Patients begin to take action on Level 3 but may not have the confidence or skill to support their behaviors. At Level 4, patients have adopted behaviors to support their health but may not be able to maintain them in the face of life stressors, she says.

Patients with low activation feel overwhelmed by the task of managing their health.

"They don't have good problem-solving skills; they have experienced failure, and are discouraged. They aren't focusing on their health because it is a difficult topic for them," Hibbard says.

Individuals whose score indicates that they are highly activated are more likely to have health screenings, immunization, and other preventive care and to exhibit healthful behaviors such as maintaining a healthy diet, exercising, monitoring their condition, adhering to treatment, and seeking information about their condition and their health, Hibbard adds.

"People fall at different points ranging from low activation to high activation. If disease managers understand where people are and support them in understanding their barriers and issues, they can help them become more activated and, in doing so, learn to take better care of themselves," Hibbard says.

Clinicians are trained to educate people about their health conditions, give them directions, and expect them to follow them, Osmick says.

"In disease management, we sometimes unwittingly ask people to do more than they are capable of doing. That doesn't work. It often turns people off and drives them more deeply into becoming less activated in their own health care. When we talk to someone at Level 1 about goals and action plans, monitoring blood pressure and blood sugar, it can be overwhelming," she says.

Patients on Level 1 of the activation scale feel they can make no impact on their own health, and asking them to monitor their blood pressure or weigh themselves may be a waste of time. Instead, the nurses help them understand how what they experience can be related to their health. Coaches work with them specifically to support them achieving a higher level of activiation, Osmick adds.

"We use this tool to help us throttle back and find out where someone is, then carry them forward by working with them to increase their knowledge, skills, and confidence," she says.

For instance, during the study, the nurse coaches worked with patients at Level 1 to build self-awareness and understanding of their behavior patterns. They worked to build a foundation to enable the patients to go on to the next challenge.

When patients were on Level 2, the nurses worked with them on making small changes in their behaviors, such as eating smaller portions, taking the stairs instead of the elevator, and reading food labels at the grocery store.

The nurse coaches took small steps and worked on one issue at a time, rather than overwhelming the patient with a whole list of goals, Hibbard says.

"The coaches work on one thing that the patient wants to do and focus on building confidence by taking small steps. Instead of asking them to go the gym five days a week, the coaches ask them to take smaller steps, like walking to the corner and back. As they experience success, the patients start to feel more confident, and that builds motivation to start managing their own health," she says.

The coaches work with the patients who are low on the activation scale to build a foundation to go on to the next challenge.

LifeMasters has adapted the tool as part of its disease management model and uses the tool for every client who willing and capable of answering the questions, Osmick says.

"Using this tool is like taking a patient's vital signs. It helps us begin to identify the person's needs and to coach to the level that will be most effective. When we know the participant's level of activation, we can specifically coach to that

level and avoid overwhelming the program participants," she says.

LifeMasters' overarching goal is to improve the activation among the population it serves, Osmick says.

"We know this leads to lower cost, higher adherence, improved clinical measures, and better outcomes. It is heartening to see the progress we made when we used the PAM tool. Effective coaching is about helping people develop the information, skills and motivation to do the right thing for their health. That is a challenge we must respond to," she says.

(For more information on the PAM tool, see www.insigniahealth.com.). ■

Research provides clues to adherence strategies

Study looks at its impact

HIV clinicians often work with patients who have such an overwhelming number of barriers to optimal treatment adherence that it's difficult to know where an adherence intervention should begin.

There are issues of homelessness, substance use, mental illness, stigma, drug side effects, etc. Primary care physicians will see the chief problem as being one particular barrier, while specialists and case managers might think a different problem should be targeted.

Now at least one researcher who approaches treatment adherence from the perspective of a nurse believes the best possible intervention will incorporate a variety of disciplines and approaches in one package.

"I remember having a few conversations with the medical director, saying, 'What you need in a program like this is a theoretical approach that different disciplines can agree on and to approach care from this perspective,'" says **Donald Gardenier**, DNP, FNP-BC, a nurse practitioner, assistant professor, and clinical program director in the division of general internal medicine at Mount Sinai School of Medicine in New York, NY.

"That's not an unusual approach for a nurse; but the medical director being a physician was intrigued and unfamiliar with this," Gardenier recalls. "So I dove into this a little bit further and came up with a social support theory as a way to contextualize care in this setting."

Gardenier's work has led to research into an adherence intervention approach for HIV-infected patients who qualify for enhanced services based on one or more threats to optimal adherence or health outcomes in terms of their HIV disease.

"These can be multiple medical problems, decreased social support based on family systems, homelessness, incarceration, and almost all of them have at least one psychiatric diagnoses and substance use issues — either currently or in the past," Gardenier says.

The patients attend an AIDS day health care (ADHC) program to which they are referred by providers based on their need for psychiatric services.

"The services are based on the statistical or evidence-driven needs of people with HIV, including housing services and nutrition services," Gardenier says. "These are in addition to being basically a psychiatric day treatment program with onsite primary care."

Gardenier first studied the ADHC's population, comparing patients' participation and reported adherence and measured social support.[1]

"I used the Social Provisions Scale [Cutrona & Russell, 1987], which was uniquely suited to this population," Gardenier says. "So it seemed to me in looking at it as a nurse that different disciplines could look at different aspects of social support and design different interventions around them."

It's not as useful to ask clients if they have social support because clients might list having a spouse, although their mate is not socially supportive or they might not think to mention the social support they receive from peers in the day program, he explains.

"Some studies say it doesn't matter where you get social support so long as you're getting it," Gardenier adds.

In the Social Provisions Scale, social support is measured with 24 items, divided between six subscales, including: reliable alliance, attachment, guidance, nurturance, social integration, and reassurance of worth.

Reliable alliance and guidance are the types of support an HIV patient might receive from the medical professionals who help him or her, Gardenier says.

The more emotional support provisions involve attachment, nurturance, social integration, and reassurance of worth, he adds.

"Attachment is the closeness and intimacy that

fosters a sense of security," Gardenier says. "Social integration is a sense of belonging to a group with similar interests and concerns."

HIV patients who experience reassurance of worth are given recognition of their abilities and competence, and nurturance is the feeling that one is needed by others, he adds.

When Gardenier measured social support among the ADHC population, he found that the highest social support scores were among the instrumental provisions of reliable alliance and guidance.

"This was not a surprise because people are in this intensive program, receiving guidance," he says. "And among the emotional provisions, the highest scores were in social integration, which is belonging in a group and also was not a surprise."

The HIV clients reported the lowest social support in the area of nurturance, suggesting they did not feel needed, he says.

"If you think about how someone experiences life during and after substance use, I think it's fairly common in the pathology of substance use to find that people who otherwise rely on you learn not to," Gardenier says. "So even when you go through a recovery period, you lack this social support."

HIV patients struggle with the feelings that they're unneeded, but this also is a social support that a comprehensive HIV/AIDS program can foster, he notes.

"We had one man in the program that really had his life together, and he came to the day program every day for years, participating in all the groups," Gardenier recalls. "He had a key spot in social integration in the place, and you had to ask what he was doing there because he had his life together."

The answer was that the man showed up each day because he felt needed, and so his attendance fostered the experience of nurturance, he adds.

"Once I saw the limitations of what I could do in correlating social support and adherence in using this instrument, there was more than enough material to use and apply toward the design of an intervention," Gardenier says.

There's considerable potential for such an adherence intervention, he notes.

"I can see how a case manager would look at this and see how to teach services to clients, who could then provide services for each other," Gardenier explains. "For example, a peer could lead an HIV group, and then you'd re-measure adherence and see how that has changed with the peer."

Reference

1. Gardenier D, Andrews CM, Thomas DC, et al. Social support and adherence: differences among clients in an AIDS Day Health Care program. *J Assoc Nurses AIDS Care*. 2009; E-publication. ■

Use data to target your wellness efforts

Employee interest key to success

Every occupational health program requires resources, ranging from tens of thousands of dollars for a fitness center to a few hours spent on educating employees. How do you decide whether these are best invested in a diabetes lunch and learn, a weight loss competition, or otherwise?

"Although occupational health providers have a trusted relationship with the employer, and are critical to maintaining good employee health in general, they are often not included in the planning and implementation of wellness programs," says **Bobbie Orsi**, MS, RN, CDE, director of occupational health and wellness at Berkshire Health Systems in Pittsfield, MA.

However, no one else understands the specific health risks of the employees in your workplace better than you, says Orsi. Here are some ways to use that information to drive decisions about occupational health programs:

- **Examine actual expenditures.**

"We are always looking at what might affect our expenditures with regard to health care claims, workers' comp claims, and short-term disability pay-out for employees that are paid at 100% when out of work," says **Judy A. Garrett**, health services manager at Syngenta Crop Protection in Greensboro, NC. "We are self-insured and handle our short-term disability in-house. So all of these would be direct costs to the company."

- **Predict the participation you'll get.**

Determine how likely employees are to participate before launching a program. "When we look at a program, we look at the number of people that it will affect," says Garrett. "Regardless of what we think might be valuable, if there is no interest from the employees, we will probably have poor results."

To gauge interest, employees are surveyed when they attend lunch and learns or participate in an online program. "The impression is given

that in order to get points for the program, they need to complete the survey. Most people will do them that way," says Garrett. "We also sometimes do surveys in the clinic, when they register to be seen or at screenings. We get less response with a general e-mail survey, unless we tag on prizes or a raffle drawing."

At Baxter Healthcare in Thousand Oaks, CA, employees were surveyed about what type of wellness program they were most interested in. Based on the findings, occupational health nurse **Robin Alegria**, RN, COHN-S, says that "we are looking at proposals for an exercise program to be held at the facility. Also, we will schedule four to six lunch and learn sessions for 2010, as well as biometric screening."

In a second survey, Alegria asked employees, "What do you feel are the top three health condition risks for employees at this facility?" "The question was not aimed at asking the employee what their own personal health risks are," she says. "By asking the question in this format, it was felt there would be a more honest response to the survey."

• **Use all data available to you.**

"Conventional occupational health reports focus primarily on injury type and frequency, lost work days, vaccine compliance, and flu immunization rates," says Orsi. "Think more broadly about what information is available to you." To get it, Orsi recommends these three practices:

• Collect information on body mass index, blood pressure, cholesterol, depression, and smoking prevalence at pre-employment or return-to-work visits.

• Collect health risk data at every employee visit, and enter this into a database.

• Obtain aggregate data reports to see how the company's smoking prevalence and other health risks compare to national trends.

Armed with this information, Orsi says you now have an opportunity "to recommend and deliver wellness programs focused on key health risks in the population." ■

Three types of health data you should not ignore

Look for common themes in data stream

Workers' compensation claims, employee assistance program utilization, employee opinion surveys and productivity questionnaires. Which are the most reliable data to base important decisions about wellness programs?

"In my experience, the best strategy is to review all possible data sources available and identify common themes," says **Bobbie Orsi**, MS, RN, CDE, director of occupational health and wellness at Berkshire Health Systems in Pittsfield, MA. "These are most likely indicative of the primary health risks and behaviors."

If your decisions aren't data-driven, you'll get disappointing results in terms of reducing health risks. "And now that wellness has become a serious health cost management strategy, failure to move in that direction will jeopardize the impact of a wellness initiative. It will risk its elimination when resources shrink," says Orsi. "I often hear that an employer has a commitment from the top to develop a wellness strategy, but in fact the program has a very small budget."

Wellness programs may begin small and grow slowly over time, by utilizing positive outcome data. "Interest surveys help to determine what employees want, which is often not what they 'need,'" says Orsi. "Health risk assessments [HRAs] tell us what employees need, which is not always what employees want. So the best strategy is to offer both." Don't fail to utilize these three data sources:

• **Health insurance claims data.**

"While these data represent events and illnesses that have already occurred, they give some information about the major health issues that are driving cost," says Orsi. "Health claims can also provide some insight into the health care decision-making practices of a population." For example, it can tell you how often employees use the emergency department for non-urgent care, or how many are utilizing smoking cessation programs.

• **HRA data.**

This gives you a "group snapshot" of common health risks such as diabetes, hypertension, obesity, and behaviors that drive risks such as physical inactivity, unhealthy eating habits, and smoking. "For the most part, HRA data are self-reported. So an individual needs to know their cholesterol and blood pressure numbers to receive an accurate health profile," notes Orsi.

Orsi says that HRA data are most useful in driving program design when participation rates are greater than 60%, so consider incentives to increase participation.

• **Data obtained from employee health screenings.**

This gives you an golden opportunity — a chance to obtain verifiable health metrics during a face-to-face encounter with the employee. "Employees are more likely to make positive change and take that 'next step' when armed with good personal health information and a motivating nurse coach, in a safe and comfortable environment," says Orsi. ■

Put weight loss reminders throughout the workplace

Aim for long term change

Many employees at your workplace probably need to lose some weight — possibly a significant amount of weight. On the positive side, though, the majority of these individuals probably really want to achieve this.

After a 2007 Health Culture audit was done for Alexandria, LA-based RoyOMartin Lumber Company, nurses and company leaders learned that 70% of employees eat a high-fat diet, and 67% would like to lose more than 10 pounds.

"Our company health care costs have remained relatively flat over the last five years, which is truly remarkable compared to national averages," says **Collene Van Mol**, BSN, RN, COHN-S/CM, the company's occupational health manager. "It is clear that we are headed in the right direction with wellness and by closely managing our insurance costs and claims, but we still have a long way to go in changing our overall health culture."

A repeat analysis conducted in 2009 showed a positive improvement in the 2007 numbers. Ninety-five percent of survey participants reported trying to make lifestyle changes within the last year. Unfortunately, only 8% reported long term success.

For this reason, RoyOMartin focused on Healthy Nutrition in 2009, providing lunch and learns with nutrition education throughout the company. "We thought, 'Feed them and they will come!'" says Van Mol.

A wide range of easy-to-prepare meals were offered, which correlated with weekly presentations on portion control, fast food facts, and healthier options. The program also covered how to shop for and prepare healthy foods at home, vs. eating out.

Participants rated their satisfaction with the program material, the speaker, and the food served each week and had to note what they learned each week. "Our goal was to find out if employees learned something new and useful," says Van Mol. "Employees were shocked to learn the fat, sugar, and sodium content in so many boxed, canned and fast food choices."

The surveys' showed this "show and tell" approach was effective. Employees were provided recipes for healthy food served and were provided fast food fact guides to use the information they had learned.

Here are changes RoyOMartin made to help employees with weight loss efforts:

- **Weight loss challenges are held.**

As part of RoyOMartin's Winning With Wellness program, employees set personal health goals to decrease risk factors for heart disease. Most often employees choose a goal of losing weight. "As a group, our employees lost over 1,000 pounds in 2007, 850 pounds in 2008, and 1,246 pounds in 2009," says Van Mol. "The individuals who participate enjoy the support of a peer group in their efforts to lose weight through our 'Losing to Win' weight loss challenges."

- **Incentives are given for eating healthy.**

In addition to a "no donuts" policy for company-sponsored meetings, RoyOMartin will be kicking off a new incentive program in 2010. "We made providing healthy vending choices a priority in 2009. Now, we want to encourage our employees to consistently eat healthy," says Van Mol.

High-fat pastries and energy drinks were removed from vending machines, and fresh salads, sandwiches, and frozen dinners with vegetables were added. After purchasing these healthy choices items, employees will remove and attach program stickers to a "Winning With Wellness" points card to be redeemed for quarterly incentives. **(See related story on a way to offer weight loss programs onsite, below.)** ■

Team up with others to offer program onsite

At ExxonMobil's Torrance (CA) Refinery, the company pays part of the cost of participation in a weight loss program. "Weight Watchers offers its programs at work locations if enough people sign up for a specific period of time," says **Julie Rochefort**, RN, MSN, NP-C, an occupational health nurse at the company's Torrance

Refinery. "The minimum is 12 to 15 people, but it's difficult to get people to participate, especially with pressure from family and work."

The first session was held onsite with 25 participants. However, after the 17-week program was completed, only ten employees signed up for the next session.

Instead of cancelling the program, however, Rochefort found a way to partner with another nearby employer. "So our folks go down the street and participate in their lunch room instead," she says. ■

Your ergonomics program might be wasting money

New furniture isn't enough

If your efforts to reduce musculoskeletal pain fall short of getting results, it may be because you bought ergonomic desks and chairs, but failed to have these set up by a professional.[1]

When The World Bank moved to its new Washington, DC, headquarters, researchers gave one group of office workers new ergonomic furniture and written instructions on how to set it up, while another group had theirs set up by an ergonomics expert. Only the second group reduced musculoskeletal pain and eyestrain, and they also increased productivity.

The study's findings indicate that equipment such as adjustable chairs don't add value unless an individual work station assessment is done, says **Jasminka Goldoni Laestadius**, MD, PhD, an occupational medicine specialist at The World Bank.

Laestadius says that multiple factors determine the success of any office ergonomic program. In World Bank's case, new ergonomic furniture was purchased; hand-outs were distributed about workstation self-adjustment; videos were shown on computer use techniques and adjusting the chair and monitor; information was provided online; satisfaction surveys were conducted; and a streamlined system was implemented to follow up on staff medical inquiries.

However, only individual ergonomic assessments of workstations made a significant difference in improving pain symptoms and productivity. Laestadius says that she wasn't too surprised by this. "Instructions for self-adjustment of various elements of computer equipment and furniture are rather complex," she says. "Our employees, who struggle daily with the heavy workload in their demanding jobs, rarely can focus on anything else."

The study showed that staff were barely aware of videos on office layouts and available equipment. "So, investment in creating these video demonstrations was obviously not beneficial at all," she says. In light of these findings, avoid investing time and money in unproductive intervention measures, such as overwhelming staff with written educational material.

Since individual assessments of workstations was very time consuming, a "train the trainer" program was used. The professional ergonomists

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CE questions

9. Keystone Mercy Health plan's blended model of care management began in 2004.
   A. True
   B. False

10. Which risk factors increase a person's chance of developing heart disease or diabetes?
   A. tobacco use
   B. high body mass index
   C. hypertension
   D. all of the above

11. In the study conducted by Judith Hibbard, PhD, and her colleagues at the University of Oregon, ED visits for the control group increased by how much?
   A. 10%
   B. 15%
   C. 20%
   D. 25%

12. Which is most helpful to maximize the benefits of new ergonomic furniture?
   A. Providing employees with handouts on how to adjust workstations.
   B. Performing individual assessments of workstations.
   C. Showing videos on how to adjust chairs and monitors.
   D. Providing written instructions.

Answers: 9. A; 10. D; 11. C; 12. B.

taught the basics to "ergo champions" who volunteered to share this information with their departments. "This approach was very successful, and helped us to reach out to more employees," says Laestadius.

Reference

1. Laestadius JG, Ye J, Cai X, et al. The proactive approach – Is it worthwhile? A prospective controlled ergonomic intervention study in office workers. *J Occup Environ Med 2009*; 51(10):1116-24. ■

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. ■