Case Management ADVISOR™

*Covering Case Management Across The Entire Care Continuum*

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## IN THIS ISSUE



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# Care coordination helps seniors live independently at home

*Program cuts hospitalizations, ED visits*

Senior citizens are living independently longer and staying out of the hospital and emergency department thanks to client-centered care coordination through two programs developed by UPMC, a large integrated health care delivery system with headquarters in Pittsburgh.

Living-At-Home and Staying-At-Home are offered to older adults who live in their own home, in an assisted living facility, or in a retirement community in Allegheny County.

The Staying-At-Home program is the outgrowth of UPMC's Living-At-Home program, a program that has provided geriatric care management to low-income seniors since 1987.

It started out as a pilot project under a grant from the Robert Wood Johnson Foundation.

"The program showed very positive results, and when the funding lapsed, UPMC continued to support the program even though insurance wouldn't pay for it. Our outcomes data that we collect through random chart audit show that we continue to decrease hospital and emergency department visits and increase compliance with physician visits," says **Shikha Iyengar**, vice president of geriatric services for UPMC.

Living-At-Home serves low-income seniors in 14 Pittsburgh neighborhoods and is subsidized by UPMC at no cost to the clients.

The Staying-At-Home program, begun two years ago, covers all of Allegheny County and charges a fee to individuals who can afford to pay for the services.

"Most of the clients in Staying-At-Home pay out of pocket, but our cost is lower than that of other case management programs in the country. We like to think we can do more for the clients because we have the backing of the entire UPMC health care organization, and we often make referrals to various geriatric programs within UPMC," says **Missy Sovak**, MSW, director of the UPMC Staying-At-Home and Living-At-



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Home programs.

Both programs are served by the same staff and offer the same services depending on the client's needs.

The clinical staff include geriatric care coordinators who have a bachelor's degree in social work or a health care-related field and clinical coordinators who are nurses. Each care coordinator has a caseload of about 100 clients.

"Older adults don't need a nurse every time. Most of the care coordination can be done by health care professionals who understand the needs of an aging population, the health care delivery system, and what kind of support system is needed," Iyengar says.

The nurses are involved in only 30% of the cases. The other 70% are handled strictly by the care coordinators, says **Charlotte Birchard**, RN, clinical coordinator.

"For most older adults, the need for skilled care is secondary. Their primary needs are support systems and someone who can help them navigate the health care system. The goal of our program is to keep our older patients stable and delay institutionalization," Iyengar says.

The medical director and the geriatric pharmacologist in the program are from UPMC's division of geriatric medicine and work with the nurses and care coordinators to ensure that all of the clients' needs are met.

Staying-At-Home and Living-At-Home are successful because they take a proactive approach to coordinating care for senior citizens, Iyengar points out.

"Our health care system is focused on providing the best care for older adults. If you wait until they get to the hospital to provide care coordination, they will have more complications and complex needs," she says.

Clients are referred to the program by home care nurses, hospital social workers, physicians, individuals in the community, or the clients themselves.

When someone is referred to the program, a geriatric care coordinator visits his or her home and completes a comprehensive assessment that includes demographic information, information on the patient's physical condition, the client's psycho-support system, the client's living situations, and all the medications the client is taking. All clients also are screened for depression and referred for whatever interventions they may need.

The care coordinators stratify clients into one of two levels of care.

Clients on Level 1 don't have pressing clinical needs but may need social support. The care coordinators contact them by telephone or in person monthly, or more often if necessary.

Clients on Level 2 have more clinical issues and need more intensive management and assistance with medications.

If the client needs assistance with medication or has complex needs, the care coordinator makes a referral to a nurse, who goes to the home and completes a skilled nursing assessment and medication reconciliation.

In these cases, the care coordinator collaborates

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with the nurse who handles medication reconciliation and other clinical issues while the care coordinator handles the social needs of the client.

The care coordinators develop a care plan based on the client's strengths, interests, abilities, and capabilities.

"The focus is on prevention and getting to the person before they have a downward trajectory and decline in function," Iyengar says.

The care coordinators set a schedule of when to see or call the clients, depending on the needs of the seniors.

"People who don't require a lot of services and have a support system in place but want to be part of the program in case they do have needs may be visited every three months or receive a phone call every one or two months," says **Mark Shaw**, lead care coordinator.

The care coordinators help clients make their doctors' appointments and call them and remind them to attend. If the senior needs help, such as housekeeping assistance or help with meals, the care coordinator arranges with community agencies to provide the services.

"Sometimes the needs of the clients are as simple as coordinating doctors' appointments and arranging transportation. We've signed many of them up for transportation assistance and taught them how to order the access van," Shaw says.

The care coordinators are assigned by zip code and get to know the formal and informal services available for seniors throughout the community.

For instance, some churches offer free lawn care service to seniors in the summer months, Shaw adds.

When seniors in the Living-At-Home program need assistance, the care coordinators can call on a volunteers, who make friendly phone calls to older adults, visit with them, help them with grocery shopping, and escort them to doctors' appointments, Shaw says.

When there are compliance issues, the care coordinators drill down to find the reason.

"Cost is often a major factor in nonadherence. The care coordinators and clinical coordinators work with the client and the primary care physician to come up with a medication regimen that can enhance compliance," Iyengar says.

If the senior needs assistance with medication, the nurse gets an order from a physician and pre-fills pill boxes for a two-week period to make sure the client adheres to his or her medication regimen.

The nurses also may pre-fill insulin syringes or give the client B-12 injections so the senior doesn't have to go the physician office, Birchard says.

One of the program's most successful initiatives is the personal health care diary, Iyengar says.

The document contains key information the patient needs when he or she has a doctor's appointment or presents in the emergency department.

The care coordinators enter the information they get on intake into the diary and update it on an ongoing basis. Seniors are encouraged to keep the diary in their purse or pocket and take it with them when they see a doctor.

It includes demographic information, the patient's living situation, contact information for the primary care physician and specialists, contact information for family members and/or other caregivers, activity level, health problems, current medications, and preventive procedures and screenings such as pneumonia vaccine, osteoporosis screening, shingles vaccine, and vision and dental visits.

The diary goes into details on health problems, such as shortness of breath, as well as including detailed information on chronic diseases and conditions, Iyengar says.

"It takes our preventative, proactive approach in managing care to a new level. The diary has everything physicians and paramedics need to treat the patient. It contains contact information for family members and other support that is in place, a list of physicians treating the client, and a list of medication so the paramedics or emergency room staff don't have to look for pill bottles or rely on the senior's memory," Sovak says.

If patients are hospitalized, the care coordinators make sure the hospital health care team has complete and appropriate information about the patient. They work with the hospital case managers on discharge planning to make sure the client is discharged to the most appropriate setting and help with the transition.

If a client is going home with home health services, the nurses work with the home health agency to smooth the transition but don't see the client until the home health regimen is completed in order to avoid duplication of services.

The care coordinators work with the clients and their families to create plans for the future, going beyond health care advanced planning, Iyengar says.

"Since there may be a time that they have to move out of a large home, we educate them on housing options. If they are not able to manage financially, we connect them with an organization that may help with bill paying. We try to help them look ahead so that they aren't so shocked when their living situation has to change," she says.

Clients stay in the program indefinitely.

Some of the clients have been in the program for nearly 20 years, Sovak says.

"We coordinate care for seniors who are well and living at home, through their disease process and to the end of life," she says. ■

# Bipolar DM helps with medication adherence

*Program reduces hospitalizations*

WellPoint Inc.'s disease management program, designed to improve care for members with bipolar disorder, reported a 22% increase in medication compliance and a 14% decrease in behavioral inpatient services for members during a recent outcomes revaluation.

The program started in 2004 in Colorado and was expanded into California, then into other Anthem Blue Cross Blue Shield programs in Ohio, Indiana, Kentucky, Illinois, Wisconsin, Missouri, Georgia, and Nevada, says **Sue Smith**, PhD, RN, CCM, medical manager for WellPoint's bipolar condition care program.

"We have expanded gradually as we found that we were successful with increasing medication compliance. We are always looking at ways to help individuals who have medical problems and coexisting psychiatric issues. It's a win-win situation. The program results in substantial savings as well as giving members a better quality of life," says **Martin Glasser**, MD, medical director of the program.

The goal of the bipolar condition care program is to help members with bipolar disorder achieve their optimal health through education and care management support.

"When we engage patients, we find that lack of medication compliance is a big issue. Life stressors are another problem they face, and that's one reason we stay engaged. Stress often is the reason the patients get worse, and we work to help them with it," Smith says.

Medication adherence is a critical component in treating bipolar disorder because it impacts short-term recovery and long-term stability as well as the overall cost of care for the patient's psychiatric and medical needs, Smith points out.

Many patients with bipolar disorder do not take their medication as directed, she adds.

"It could be that they no longer feel they need it or they don't like the side effects and they stop taking them. In some cases, patients are challenged to afford their medications. Since those medications were helping stabilize them, they are likely to exhibit manic symptoms," she says.

Members who are eligible for the program are 18 years of age or older with a diagnosis of bipolar disorder and are being treated with medication.

Patients also are identified for the program through clinical reviews and pharmacy reports. In addition, members can call the health plan's resource center and be referred to the program when they need help in finding therapy or need other support.

"There are multiple points of entry into our system. We do data mining as well as working extensively with the medical management team and behavioral health utilization team. We see many members who are being discharged from the hospital with bipolar illness who require case management," Smith says.

The program is voluntary. Members who agree to participate in the program are stratified based on the severity of their condition after screenings for acuity, depression, and past history.

Each member is assigned a case manager, an experienced, licensed therapist with a master's degree or higher. The case managers make appointments to call the member on a periodic basis.

If the member's bipolar illness is in a high state of acuity, the case manager may call on a weekly or even a biweekly basis.

Once the patient's condition is stabilized, the case manager may call only once a month, then every few months, Smith says.

"We try to identify them early on when they are first diagnosed and send them materials explaining the condition and what effect it could have on their lives. Then we call them and offer assistance," Smith says.

In a typical scenario, someone with bipolar disorder goes into the hospital completely stressed, gets treatment that helps get the condition under control, and is released back to the community without the services they need, Smith says.

The bipolar condition care program gives them the support they need to adhere to their medication regimen and stay stable, she adds.

"We make an outreach call to anyone who is discharged with bipolar illness as the primary diagnosis to see how they are doing and to work with them so they'll be adherent to their medication regimen. We help them get established with a psychiatrist so they can get the treatment they need," Smith says.

People who are newly diagnosed with bipolar disorder often test the waters and stop their medication to see if they really need it, Glasser says.

"Then they cycle into a manic state and need to be hospitalized. When we are engaged with them, we can tell when they are starting to act a little different, then find out that they stopped their medication and get them to restart it," Glasser says.

The case managers work with their clients to problem-solve and focus on medication adherence. They connect with the member's health care providers to make sure they are getting the services they need.

The same case manager works with the member as long as he or she stays in the program.

"The relationship that the member builds up with the case manager over time is one of the biggest factors in the success of this program. When individuals with bipolar disorder experience a medical crisis, family problems, or an emotional crisis, they tend to regress and end up in the hospital unless they have help and support. Our case managers get to know them and help with stresses in their lives that could cause an exacerbation of their condition," Glasser says.

The case managers work with the patients to solve the problems that prevent them from taking their medication.

"We want to reduce hospitalizations among these patients, and that means working closely with them to keep them stable," she says.

Medications for bipolar disorder can have many side effects, including weight gain, acne, and loss of sexual function, Glasser says.

"The medication makes patients feel better immediately when they are used according to guidelines, but the side effects can be insidious and get worse the longer the patients are on it," he adds.

When the case managers pick up a concern about the medication or side effects, they empower the member to talk with his or her psychiatrist or primary care physician about it, or if the member requests, the case manager or Glasser calls the physician to discuss the problem.

If the member wants to talk to the provider but is not sure what to say, the case manager sets up a conference call.

"We also work with the physicians to clarify situations we consider to be a safety issue. Multiple providers don't always communicate. We try to engage every provider who is treating the patient and keep them informed about what the team is doing," Glasser says.

For instance, the bipolar team informs the psychiatrist of what medications the primary care physician has prescribed and vice versa. If the patient is starting to drink alcohol, they make sure the psychiatrist is aware of it. The bipolar team keeps the primary care physician and any other treating physicians informed about the patient's progress and problems.

"Many programs collaborate only with the therapist. We try to be all-inclusive and work with the entire treatment team. Our program is unique because we try to engage all physicians and therapists involved with the patient in coordinating care for the member," Smith says.

The case managers in the bipolar program work closely with their counterparts in disease management to coordinate care for patients with bipolar disorder as a secondary condition.

"We have a collaborative, holistic approach with our disease management and medical management programs. We work together with the nurses in the other program to ensure that the members receive all the help they need," Smith says.

For instance, if a member in the diabetes disease management program is identified as someone who has had bipolar disorder, the disease manager will make a referral and a case manager from the bipolar program will contact the member and complete an assessment to determine if he or she needs help.

The case manager makes an outreach call to determine what issues the patient is having that make it difficult to get his or her prescription refilled. It may be that he or she is having financial problems or has not seen the physician for a new prescription, she adds.

The bipolar team holds rounds each week, during which the case managers bring up challenging situations and get peer support.

"There is a lot of ongoing monitoring and discussion going on to ensure that the patients are getting everything they need to learn to manage their disease and improve their quality of life," Glasser says.

The program is very popular with participants and always receives high scores on member satisfaction surveys, Glasser reports.

"We have multiple success stories from our members and from the case managers. The members really like the program and they're quite vocal with their compliments. Our metrics support a significant reduction in the cost of care for the members by reducing hospitalizations, readmissions, and by continued engagement and coordination with providers," Glasser says. ■

# Ensure patients, families informed after discharge

*Offer all options, including private duty services*

When you are developing a post-discharge care plan for patients who will need some assistance at home, make sure the patient and family understand what is required of them and that they are aware of all their options, including paying for private home care services.

Patients must be able to care for themselves or have a primary caregiver in order to be considered appropriate for home health services or hospice services paid for by any payer, whether it's Medicare, Medicaid, or commercial insurance, points out **Elizabeth Hogue**, Esq., a Washington DC-based attorney specializing in health care issues.

Case managers should make it clear when the patient will need care between visits from the professional staff and be as specific as possible about the role of the primary caregiver and the tasks that they will be expected to perform, and the time frame in which the patient is likely to need care.

"Potential caregivers may be reluctant to care for incontinent patients, to dress wounds, and to give injections. If this is the type of care that is needed, case managers should clearly explain these activities to potential caregivers," she says.

It is helpful if case managers help potential primary caregivers realistically evaluate whether they can provide all of the care the patient will need and realistically evaluate if they can perform the tasks, she adds. For instance, if a patient needs assistance with multiple transfers, a caregiver with back problems may not be appropriate for the role.

"Patients' family members or others may be willing to fulfill the caregiving role on a voluntary basis. If not, case managers should explore the option of using paid primary caregivers to meet the patient's needs in between visits from professional staff," she says.

Home health agencies, private duty agencies, and hospice agencies may be able to provide private duty services including sitters, live-in staff, and health care aides, Hogue says.

Offer the option to pay for private duty home care services to all patients who can benefit from the services, Hogue suggests.

Even patients who can care for themselves or who have volunteer caregivers may welcome additional assistance, she points out.

"Discharge planners or case managers may be reluctant to offer these services to patients and their families because of the cost. They may erroneously conclude that patients and their families cannot afford these services," she says.

Don't jump to conclusions about what patients and families can or cannot afford, she says.

"Offering private duty home care services is consistent with legal and ethical requirements that govern the practice of case management," she says.

From a legal point of view, hospital case managers must comply with Medicare's Conditions of Participation, which require discharge planners or case managers to develop appropriate discharge plans, if necessary, for all patients.

"Development of appropriate discharge plans undoubtedly includes private duty home care services for patients who may benefit from them," she says.

The Case Management Society of America's national standards of care for case managers make it clear that case managers have a duty to advocate on behalf of their patients, Hogue points out.

"As advocates for patients, case managers have an obligation to make sure that patients understand all of the options available to them, including the option to pay for private duty home care services, she says.

Ethical principles require case managers to provide information to patients so they can make informed choices, she adds.

"Patients cannot make choices about the care they wish to receive unless they have information about all services available, including private duty services. Consequently, case managers have legal and ethical obligations to make sure that all patients have information about private duty home care services," she says. ■

# Workers' comp costs are linked to depression

*Depression screening is cost-effective*

Three factors — depression, stress and obesity — together account for about half of the variance in the average workers' compensation cost per case at PPG Industries. That is based on data from health risk assessments completed by several thousand of the company's employees, and analysis of five years of workers' compensation claims at 35 worksites, according to **Alberto M.**

**Colombi**, MD, MPH, medical director.

"Depression screening is the most important tool that can be promoted in the realm of mental well-being," says Colombi. "It has direct bearings on occupational health and productivity. We found that the percentage of people that screen positive for depression, together with other factors, has an important impact on overall worker's compensation costs."

The findings indicate that depression is a contributing factor in a multi-factorial process, not the sole factor affecting workers' compensation. "Treating depression as a linear and isolated factor is a serious mistake, in my opinion," says Colombi.

When depression, obesity, and stress are all set at their median level, the average payment for a workers' compensation case was found to be $4,612. However, if obesity prevalence at that worksite increases from its median of 0.34 to .05, the cost increases 84% to $8,519.

Conversely, if the proportion of workers reporting a neutral stress and satisfaction score improved from the median of .33 to .45, the average cost per case would decrease by 63%, to $2,918. Finally, if all other factors remained unchanged, and the percentage of workers screened for depression at a worksite was increased from its medial level of 0.25 to 0.45, that would decrease the average payment to $2,425, or 53%.

In order to determine your own return on investment from depression screening, Colombi says you need to understand three things. First, you need to know the relationship between depression and workers' compensation costs at your workplace. Secondly, you need to determine the investment required to prevent or treat depression. Lastly, compute the relationship between the financial investment and the benefits resulting from it.

"How much does it cost to increase depression screening from a quarter to half of the worksite population?" asks Colombi. "There are direct costs and indirect costs involved in this."

The direct costs are due to adding a patient health questionnaire including depression to an online health risk assessment, which Colombi says involved a one-time programming fee of $5,000.

## Single out high-risk workers for screening

Mental health screening should be part of your overall plan to assess risk, implement interventions, and establish outcomes measurement strategies, 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. She suggests the following approaches:

**1. Add questions about mental health and stress to health risk appraisals.**

"This is a valuable and low-cost way to increase awareness," says Spangler. She advises using validated tools, including the World Health Organization Health and Work Performance Questionnaire or the Work Limitations Questionnaire.

**2. Screen high-risk groups.**

These include employees with other medical conditions, people who access employee assistance programs, those who are frequently absent from work, and employees in particularly high-stress positions.

Also screen any employee who has been off work for five days or more with an occupational injury or accident. For these cases, Spangler suggests using a nine-item depression scale, called the patient health questionnaire.

"This tool may be helpful for both screening and monitoring progress," she says. Spangler points to one study that found a high prevalence of depressive symptoms at one month (43%) and six months (27%) post-workplace injury. In addition, the researchers found that few of the injured employees were receiving any treatment for depression(13% and 24%, respectively).[1]

**3. Collaborate with others in your organization who may be able to influence mental health awareness.**

Enlist the help of human resources, leadership, employee assistance, safety, and communications.

**4. Communicate with referral clinicians.**

Inform independent medical examiners, rehabilitation, and disability vendors that your organization values a comprehensive biopsychosocial approach to functional capacity examinations, work accommodations, and return-to-work strategies.

REFERENCE

1. Franche RL, Carnide N, Hogg-Johnson S, et al. Course, diagnosis, and treatment of depressive symptomatology in workers following a workplace injury: a prospective cohort study. *Can J Psychiatry* 2009; 54(8):534-546. ■

The indirect costs involved adding depression screening to the wellness programs already in place at each worksite. That cost, for PPG, was $25 per employee per year.

Thus, Colombi estimates that to reduce the average worker's compensation cost per employee by 50%, "you would need to invest $25 per employee to have a worker's compensation payment per employee saving of $500." *(See sidebar on effective ways to screen employees, page 55.)* ■

**SOURCES**

For more information on the benefits of mental health screening in the workplace, contact:

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# Don't ignore influence of peer pressure

*Identify your local champions*

Often, getting results from wellness programs requires a lot of money and time — sometimes more than you have to give. Why not capitalize on a resource that is completely free — that of positive peer pressure from co-workers? Some approaches:

**1. Find some local champions.**

"Ideally, these are people who have achieved a major wellness goal, and they're proud of it," says **Jodi Prohofsky**, PhD, LMFT, senior vice president of health management operations at CIGNA. "You just need one to get started!"

First, tell the person about the positive impact their story can have on others. "Once they tell their story, others will want to share theirs, too," says Prohofsky. "One way to find that first champion is to have an essay contest." Publish the winning essays, and then ask the winners to judge the next contest you hold. Once you get the go-ahead from an employee, publicize his or her success story through the Intranet, brown bag lunch gatherings, and team meetings.

**2. Ask employees to form teams with others.**

Prohofsky is executive sponsor of CIGNA's Healthy Life Team Challenge, a 10-week enterprise-wide weight loss and physical activity competition that encourages employees to manage their weight safely or embrace an active lifestyle. "I sent a message to all employees asking them to consider forming teams with their friends and co-workers," she says. "When people saw teams forming, it prompted them to join one or form their own. The response has been fantastic. I expect this to be a very successful, low-cost wellness initiative."

**3. Solicit stories during wellness events.**

During a diabetes education class at Alexandria, LA-based RoyOMartin Lumber Co., a 32-year-old employee shared with the group that he and his wife had recently lost a significant amount of weight. "He lost 35 pounds and she lost 20 pounds. They took a simple approach of exercising together daily and preparing and eating healthy choices together," says **Collene Van Mol**, BSN, RN, COHN-S/CM, the company's occupational health manager. "He is now off his oral medication for diabetes. His next goal is to be taken off blood pressure medication as he continues to lose weight, exercise, and eat a healthier diet."

The couple was featured in the company-wide employee newsletter, as an example of success resulting from taking personal responsibility for healthy changes.

**4. Enlist company leaders and managers.**

These individuals can serve as role models. They also have the clout to encourage employees to participate in wellness programs while at work. "Our Health Culture Survey showed that supervisors, the health and safety team, and our company leaders are well trusted by employees, with the supervisor trust rating right up there with family members. That is powerful!" says Van Mol. ■

# TN hospital: No jobs for smokers

*Policy promotes 'healthy behaviors'*

Smokers need not apply. That is the new policy of Memorial Health Care System in Chattanooga, TN.

Everyone who applies for a job at Memorial Health Care will be tested for nicotine, and employment offers will be rescinded for those who test positive. The policy mirrors that of several other health systems, including the Cleveland Clinic and Akron Children's Hospital in Ohio and Phoebe Putney Memorial Hospital in Albany, GA.

It is the natural next step after implementing a tobacco-free campus, **Brad Pope**, vice president of human resources, explained in emailed comments.

"As a hospital, our work force and the communi-

ties we serve should expect us to set the example for improving healthy behaviors and lifestyles," he said. "We realize this will not happen overnight and there will be difficult decisions to make, but that should not stop us from making the decisions that will keep us on our journey to creating healthier communities."

The hospital also offers programs for current employees who are smokers, including Freedom from Smoking, the cessation program proved successful by the American Lung Association. "Smoking doubles a person's risk for stroke and heart disease; it increases by 10 times your risk of dying from chronic obstructive lung disease, and it drives up the cost of health care," a Memorial employee newsletter reminds.

In a related development in the nation's biggest tobacco-producing state, no one can smoke or use tobacco on any campus of North Carolina's 125 acute care hospitals. North Carolina is the first state in the country to be 100% tobacco-free in its non-federal hospitals. Employees at state hospitals who smoke also pay more for insurance premiums. It is a sign of things to come as more and more hospitals remove smoking — and other tobacco use — from their campuses, not just their buildings.

"We are still the No. 1 tobacco-producing state, and we have a tremendous number of health problems as a result of that," says **Melva Fager Okun**, DrPH, senior program manager for NC Prevention Partners in Chapel Hill, a nonprofit organization that seeks to reduce preventable illness and early death. "For us to have achieved this is remarkable. It's exceptional." ■

# Educate about headaches in June

*Patients must take active role in diagnosis*

To manage chronic headaches, the sufferer must play a key role.

"Self-education is an important part. It is going to be difficult for your doctor, nurse, or nurse practitioner to put enough time in to teach you everything you need to know about managing a headache," says **Robert Dalton**, executive director of the National Headache Foundation in Chicago.

Knowing which web sites provide reliable information, as well as the right books and periodicals to read, are important, he says. Not only will personal research help people uncover methods for managing their headaches, but it will also help patients form pointed and direct questions about issues of managing headaches to ask their physician, he adds.

The message of self-education is an important one to deliver during National Headache Awareness Week, June 6-12. Also stress the importance of a proper diagnosis, says Dalton. Headache problems need to be properly diagnosed, and one reason is that chronic headaches could be a biological disorder.

Persistent or severe headache is often a biological disorder and needs proper treatment. That may seem obvious, but the reality is that many people ignore it, thinking it is just a symptom rather than a core problem in and of itself, says Dalton.

Frequently, people go to a physician that does not have extensive experience treating complex headaches. Therefore, after trying one or two common treatment regimens, they come to the conclusion that the headaches really are caused by stress or some other health issue and never find the right treatment, he explains. People with chronic headaches usually need to see a physician with expertise in treating complex headaches.

Treatments for serious headaches are not the same for each person. The right mix of medication must be determined, what types of non-medical treatments might be helpful, and the dietary issues that need to be addressed are all part of the management plan.

Patients not only play an active role in the diagnosis, but also in the treatment regimen, which is an ongoing process. Dalton says that people may find a medication that keeps them headache-free for a long period of time, but sometimes the body's reaction to the medication changes and a new treatment plan is needed.

It is a good idea for people to keep a headache log, says Dalton. This would track such information as the frequency of attacks, what was happening at the time the headache was triggered; possible triggers; types of medication taken; whether treatment steps provided complete, moderate, or no relief; and the duration of the headache.

Headaches can have a multitude of triggers, says Dalton. These include food, fragrance, noise, changes in weather, exertion such as hard physical labor, and failure to keep hydrated.

A log or diary helps physicians figure out the right regimen, he says. Log sheets for tracking headaches, as well as a series of questions to answer when keeping a log, are available at the National Headache Foundation web site (www.headaches.org). Also available are a series of quizzes that will provide information that helps with the initial diagnosis, says Dalton.

A new service found on the web site is an educa-

tion portal called "Headache U: It's all about YOU." It is a headache education program designed to help people with headaches take steps toward getting relief. It covers three key principals of headache care: the personal nature of headache; the importance of understanding personal headache patterns; and the link between charting headaches and getting relief.

Increasing awareness about headaches and proper treatment is vital, because millions suffer, says Dalton. It is estimated that 29.5 million Americans have migraines and 10 million have other types of severe headaches, such as cluster headaches. These headaches cause excruciating pain in the vicinity of the eye and occur daily for weeks or months and then disappear for a time.

There are a multitude of headache types and causes. Some headaches are not chronic but caused by such factors as drinking too much alcohol or withdrawing from the use of caffeine. Other headaches are caused by illness, such as those that develop with fever. Sometimes headaches are a symptom of another medical problem, such as a tumor or aneurysm.

However, certain benign headaches are biological disorders that need to be diagnosed and treated properly. National Headache Awareness Week is an opportunity to help community members sort out the various types and causes and perhaps find relief after years of suffering.

Dalton says chronic headache tends to influence the personalities of the people who get them, often resulting in depression or causing people to be withdrawn. Therefore, it is also important to help people address the emotional side of headaches by directing them to support groups or blogs where they can interact with other people who understand their issues.

### Source

For more information about participating in National Headache Awareness Week, contact:

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# Nonadherent patients may not understand

*Keep your message easy to comprehend*

When patients don't follow their discharge instructions and end up back in the hospital, it may be that they simply don't understand what they were supposed to do at home.

"Today's health care professionals are busy and give the discharge information quickly without making sure that the patient gets it. Patients want to do what they need to do to get better. When they are noncompliant, it may be that they just don't understand," says **Gloria Mayer**, RN, EdD, CEO for the Institute for Healthcare Advancement based in LaHabra, CA.

People who are discharged from the hospital are still really sick and have a difficult time learning and remembering a lot of material, adds **Helen Osborne**, MEd, OTR/L, president of Health Literacy Consulting, a Natick, MA, firm.

"That's why case managers must make sure that patients and family members understand what they should do after discharge and why it's important," she adds.

Medical professionals tend to use medical jargon when they speak to patients, which creates a tremendous health care literacy problem, Mayer says.

"When patients aren't familiar with the terminology the case manager uses, they miss the message and they don't understand what they need to do, so that translates into nonadherence," she says.

For instance, people who are told they have "hypertension" sometimes think that means they are hyperactive, but they may understand the term "high blood pressure." Instead of using terms such as "myocardial infarction," use "heart attack" and say "X-ray" instead of "radiology," Mayer suggests.

When you talk to patients, avoid medical jargon and technical terms you don't need to use, Osborne suggests.

"On the other hand, case managers have a responsibility to use the correct word when it's needed and explain it clearly," she says.

For instance, words such as "chemotherapy" or "dialysis" are complicated words, but there are times when people need to know what they mean, Osborne adds.

Remember that idiomatic terms such as "draw your blood" may not be understood by people who are new to the language.

Confirming understanding is an essential step in communication and one that often gets left out, Osborne says.

Teach patients as clearly and simply as you can, and ask open-ended questions on key points to make sure that they understand, she says.

Using the teach-back technique is key in ensuring that your patients understand what they should do

when they leave the hospital, Osborne says.

"We as health professionals do our best to use plain language, but doing that alone is not sufficient. We need to make sure our message is understood," she says.

When you talk to your patients and their family members, create a feeling of partnership. Use phrases such as, "I want to make sure we're on the same page," or "Let's work together to make sure you do everything you need to do after discharge."

Assess your patients' comprehension after you give them key points or new information.

Always ask open-ended questions, putting the responsibility for comprehension on you.

Say, "I want to make sure I've given you the right information."

Don't say, "Do you understand?" because the only answer is yes.

Narrow your focus when you ask questions, Osborne suggests. For instance, say, "The doctor said you need to be on a high-fiber diet. When you go grocery shopping, which cereals would you buy?"

After the patient and family members repeat what you've told them, reinforce that they have the information correct, or correct it if their answer indicates that they don't understand, Osborne says.

Try different strategies and ways of learning, such as bringing in pictures or giving examples, she says.

"If you find the person really does not understand, try to determine why they are having so much trouble. Is the issue hearing, language, anxiety, or learning skills? Think of alternate ways to teach the patient. Make another appointment and invite the family members to participate or arrange for a few visits from a home care nurse who can reinforce the teaching," she says.

Remember that patients can absorb only two or three things at a time. If multiple items need to be covered, break them into small portions, Mayer suggests.

"If people are sick, they are even less likely to understand everything you are telling them," she adds.

Limit your teaching to three concepts at a time and include the family whenever possible, Mayer suggests.

"If medication is the most important thing, teach them about medication. If they need a follow-up appointment, write down the name and telephone number of the doctor and be very specific. Tell them to call Monday and see the doctor within a week," Mayer says.

Be specific with your instructions, she says.

For instance, with congestive heart failure patients, go beyond saying, "Weigh yourself every day," because weight can vary depending on the time of day and what the patient is wearing.

Say, "Weigh yourself when you get up in the morning before you put on your clothes."

Make sure that your written instructions are simple and legible. Keep in mind that people who are just learning to read English may not recognize script and print the instructions, Mayer suggests.

Most health education materials are written between the eighth grade and college level, and about 90 million Americans read at the fifth-grade



## COMING IN FUTURE MONTHS

- How medical homes improve outcomes for diabetes patients
- Ways health coaches help patients avoid readmissions
- How case management helps low-income women with breast cancer
- Ethical dilemmas for case managers

# CNE QUESTIONS

17. Each care coordinator in the Living-At-Home and Staying-At-Home programs has a case load of about how many patients?
A. 25
B. 50
C. 75
D. 100

18. WellPoint Inc.'s disease management program, designed to improve care for members with bipolar disorder, reports a 22% increase in medication compliance.
A. True
B. False

19. According to PPG Industries, what factors account for about half of the variance in the average workers' compensation cost per case?
A. depression
B. stress
C. obesity
D. all of the above

20. Gloria Mayer, RN, EdD, CEO for the Institute for Healthcare Advancement based in LaHabra, CA, says you should limit your teaching to three points.
A. True
B. False

**Answers: 17. D; 18. A; 19. D; 20. A.**

level or below, Mayer says.

Don't use pharmaceutical company handouts. They tend to be far too complicated for the average person to understand, she adds.

Mayer suggests that hospital case managers review the materials they are handing out and make sure they are simple and to the point so every client can understand them.

"Some people argue that college-educated patients would be insulted by easy-to-read materials, but in fact, nobody ever complains that something is too easy to understand," she says. ■



## CNE 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.

## CNE 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. ■