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IN THIS ISSUE

■ Assistive technology can benefit clients in myriad situations . . . . . cover

■ Health care reform offers CMs challenges, opportunities . 64

■ Care coordination for Medicaid high-users 66

■ Workers' comp: Getting the devil out of the details. 68

■ Rewarding workers for lack of injuries is risky 69

■ Use team approach to ID worker's comp costs 70

■ Is wellness data too dismal to share? Don't be so sure. . 70

■ PAPRs end frustration of fit-test failure. 71

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Assistive technology can benefit clients in multiple situations

Consider it for clients with mobility, cognitive, vision deficits

Assistive technology can make life better for everyone and help people live independently in a safe environment, whether they have a catastrophic illness or injury or are elderly with cognitive and/or vision issues, says **Hunter Ramseur**, MEd, LPC, CDMS, ATP, principal of Atlanta-based Assistive Technology Consulting LLC.

As an assistive technology consultant, Ramseur gets referrals from the Veterans Affairs hospitals, insurance companies, workers' compensation, life care planners, and others to help choose assistive technology that can help clients live safely at home.

"Assistive technology really plays a role in offering individuals maximal quality of life. It helps keep them safe and gives them a great opportunity to be self-directed in their own care," adds **LuRae Ahrendt**, RN, CRRN, CCM, nurse consultant, Ahrendt Rehabilitation in Norcross, GA.

Ahrendt and Ramseur suggest that case managers consider assistive technology when they develop a plan of care for patients who may need help with mobility deficits, cognitive issues, or poor eyesight.

"Technology today has so many applications that allow people to be independent. As a case manager, when I evaluate clients for the first time or re-evaluate them for changes in their physical, cognitive, and behavioral status, I look for ways that assistive technology can meet their needs for safety, independence, maximal community integration, and for them to achieve optimal self-direction," Ahrendt says.

The benefits of assistive technology often far outweigh the costs, Ramseur says.

"Technology can save money down the road. If you can get somebody to be more active, they'll be healthier and happier, and less likely to utilize the health care system," he says.

The addition of assistive technology can help people stay independent in their own homes and reduce the cost of care, Ramseur adds.

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For instance, the installation of a lift system can help keep a patient with limited mobility out of a nursing home or assisted living center because it helps caregivers with transfers from the bed to the wheelchair or the wheelchair to the toilet.

With a lift system, the patient has more control in getting in and out of bed alone, and the caregiver, who isn't strong enough to lift the patient, can assist with the transfers safely, he adds.

"Just the slightest amount of empowerment can make a huge difference, even if it doesn't seem significant at first. It builds on itself," he says.

For instance, many of his clients, who are veterans with combat injuries, also struggle with emotional factors and have lost the drive to do anything.

"Some of these clients are in pain and do nothing but sit around and watch television because it's too painful to do otherwise. A lift chair is a pretty simple way to get them up and going," he says.

If technology is appropriate and safe, it often saves money in the long run, Ahrendt says.

People who have assistive technology in their home environment may not need round-the-clock care but may be able to stay alone a few hours a day and be safe, Ahrendt points out.

For instance, a spinal cord injury patient who can operate a wheelchair and has enough speech for voice-recognition technology can work on a computer, make telephone calls, and open doors using assistive technology for part of the day instead of having an aide 24 hours a day, she adds.

"Assistive technology is no longer the domain of the most catastrophically impaired individuals. People with chronic conditions, physical problems, cognitive and behavioral impairments that result from a wide range of disorders can also benefit from today's technology," Ahrendt adds.

For instance, personal digital assistants (PDAs) can be programmed to remind disease management clients to take their medication or weight themselves, saving telephone calls and home health visits.

Or, a desktop computer's calendar program can be used to set up a similar reminder system.

Voice-activated cell phones allow people with fine motor issues or those who are losing their eyesight to have a safer environment, Ramseur says.

When developing a plan of care, case managers should think outside the box as to what part assistive technology could play in improving clients' quality of life and should bring in technical assistance to help them decide on the right technology, Ahrendt says.

"Finding someone who understands the value of technology and its specific implementation for a specific client and family is a very important piece. No case manager should ever assume they have all the knowledge necessary to choose the right technology," she says.

Identify activities that are critical to what your client wants to do and look at how the activities can be accomplished with the help of technology, Ramseur suggests.

When he evaluates someone for assistive technology, Ramseur starts by looking at the activities that need to be accomplished, then looking at what the client can or cannot do.

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EDITORIAL QUESTIONS

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

Editor: Mary Booth Thomas, (770) 934-1440, (marybootht@aol.com).
Managing Editor: Jill Robbins, (404) 262-5557, (jill.robbins@ahcmedia.com).
Executive Editor: Russ Underwood, (404) 262-5521, (russ.underwood@ahcmedia.com).

"For instance, the activity that needs to be accomplished may be to access the bathroom safely. Then I assess the person's function loss and put the two together to decide what is needed to accommodate the activity," he says.

Don't just hook people up with technology. Make sure they know how to use it, Ramseur suggests.

"In almost every case, clients have a significant need for training, and it needs to happen in the home whenever possible. A lot of times, people are given equipment in the hospital and trained on how to use it, but they forget how when they get home. It's more effective to get them comfortable using assistive technology in their home environment," he says.

For instance, voice-recognition software for computers and cell phones is fairly straightforward when people are taught how to use it, but that process that usually involves several orientation sessions to make sure the technology is being used correctly, Ramseur says.

PDAs are standard issue for patients with traumatic brain injury being discharged from a Veteran's Affairs hospital, Ramseur says. However, when he goes to the veteran's home for a consultation on other technology, he often finds that the PDA has been abandoned because the client didn't understand how to use it.

Consider an ergonomic evaluation for your clients who spend a lot of time at the computer, Ramseur suggests.

"People who spend hours on the computer often have back and neck pain and repetitive stress issues in the upper extremities. If they have good ergonomics, it adds efficiency and comfort," he says.

Good ergonomics starts with a good adjustable chair with back support that fits the user's body dimensions. Other options include one-hand keyboards, ergonomic keyboards, and mouse variations, he says.

"There is so much technology out there that is becoming more universally available," Ramseur says.

Computers have opened up the world for people who have almost no function, Ramseur says.

Voice-recognition software for computers, which has been available for many years, is now in its 10th version and is 90% to 95% accurate, Ramseur says.

"This opens up a new world for someone like a quadriplegic who has limited use of his hands but his voice is still strong," he says.

There is even a product that combines hardware and software to allow someone to look at a computer screen and activate what he or she sees using a sophisticated camera calibrated to his or her eye, Ramseur says.

For instance, the screen can be set up with a virtual keyboard and when the user looks at a key, it interfaces with a laptop or desktop computer and activates a key on the computer.

"They can create e-mail documents or go to an environmental control screen and turn on the lights by looking at a certain module," he says.

One scientist who has worked on developing the product can type 30 words a minute using her eyes, he says.

"Patients who have no function at all, such as high-level quadriplegics on ventilators or people with ALS or multiple sclerosis who are losing their speech, can communicate by using this type of program," he says.

Software programs developed for people with learning disabilities also can be helpful for people with traumatic brain injury or other cognitive defects who need help with concentration and memory, Ramseur says.

Some of the software has voice output that will speak what is on the screen and highlight the words as they are spoken.

Home automation technology offers safety and security to clients, Ramseur points out.

For instance, someone who is bedridden can use a computer to check to see who is at the door, then push a button that automatically lets the visitor in.

There are low-tech options available, Ahrendt points out.

For instance, retail stores sell monitoring systems that use live-view web cams that people can use to check on their loved ones or the person caring for them while they are at work.

In addition to grab bars and zero-step showers, devices such as bath lifts can help disabled people bathe in safety and comfort, Ramseur says.

"Getting out of bed or transferring in and out of a wheelchair or bathing chair is a struggle for a lot of people. An overhead lift system can give them independence. If they have some upper-body function, they can activate it themselves," he says.

One of Ramseur's clients was a veteran with a combat-related injury that left him a quadriplegic with head injuries. His mother and younger brother were struggling to take care of him but had trouble helping him transfer from the bed to a wheelchair and to the bathroom.

"The overhead lift system allowed him to get himself out of bed and into the rolling shower chair or wheelchair. It gave him a measure of independence and gave his caregivers some relief," he says.

Ramseur recommends a global positioning system (GPS) for some brain injury patients and veterans who have issues with anxiety concentration difficulties.

"Sometimes people get distracted and forget how to get home. This is an example of how a simple thing can make a difference," he says.

Here are some links for more information about assistive technology:

- http://www.catea.gatech.edu;
- http://seniors-health-medicare.suite101.com/article.cfm/aging_in_place;
- http://assistivetech.net;
- http://awarehome.imtc.gatech.edu/.

[For more information, contact:
LuRae Ahrendt, RN, CRRN, CCM, nurse consultant, Ahrendt Rehabilitation, e-mail: lahrendt@mindspring.com;
Hunter Ramseur, M.Ed, LPC, CDMS, ATP, principal, Assistive Technology Consulting LLC, e-mail: hunterswork@bellsouth.net.] ■

Reform offers challenges for CMs

Care coordination mentioned throughout legislation

Once the details are ironed out, health care reform will offer great opportunities for case managers in a variety of settings, says **Margaret Leonard**, MS, RN-B, C, FNP, senior vice president for clinical services at Hudson Health Plan and outgoing president of the Case Management Society of America (CMSA).

Both the final Patient Protection and Affordable Care Act and the reconciliation bill contain half a dozen new buzzwords and phrases that have long been familiar to case managers, Leonard points out.

Among these are "case management," "care coordination," "transition of care," "disease management," "population management," "medical home," and "hospital readmissions," she adds.

"We are mentioned throughout the bill in so many ways. The people who drafted the health care reform know that care coordination works, but now we have to decide who is able to do care coordination and who can bill for it," she says.

CMSA has opened an office in Washington to ensure that the voices of case managers are being heard on Capitol Hill, Leonard adds.

CMSA representatives are involved in developing a model act for care management based on the standards of practice the organization just revised.

"As the details of health care reform are being developed, CMSA is taking steps to get case managers at the table to help them define case management and design the regulations to make sure that everybody is using the same terms," Leonard says.

Once the government comes up with a payment process for case management services, more opportunities are going to open up for case managers, she adds.

Since there already is a shortage of nurses, case managers, and social workers, initially at least, health care reform is likely to result in more responsibilities for people who already are case managers, points out **Catherine M. Mullahy**, RN, BS, CRRN, CCM, president of Mullahy & Associates LLC, a Huntington, NY, case management consulting firm.

"Case managers are already concerned that they have too many cases. If more people enter the health care system, it's going to put more of a burden on them," she says.

No matter where they are working, nurse case managers will need another layer of administrative support to handle clerical duties to free them up to take care of tasks that need clinical expertise, Mullahy says.

"We in case management need to do a better job of stratifying patients according to their needs and identifying which people truly need a registered nurse or a social worker as their case manager," she adds.

The team approach for case management and disease management is going to become more important, Mullahy says.

For instance, trained paraprofessionals can perform health coaching if they use a script and call on licensed staff when complex clinical issues arise. In addition, the needs of some patients can be handled by LPNs, Mullahy says.

Mullahy suggests that case management departments perform studies to determine how each case manager spends his or her time to demonstrate

the need for additional staff that could increase the efficiency of case managers.

"If the nurses are spending a lot of time on paperwork or on the telephone, those are tasks that can be performed by others. Organizations shouldn't be paying the salary of a nurse to do jobs that an administrative assistant or paraprofessional could do," she says.

The medical home concept has gotten a lot of attention in the talks about revamping the health care system, Leonard points out.

"Here in New York, physicians who receive certification from the NCQA to be a patient-centered medical home are getting as much as an additional $6 per member per month to provide care coordination," she says.

Primary care physicians and their case managers are going to be on the front lines when people who previously did not have insurance seek care, Mullahy says.

"The medical home model and guided care model will help people new to the health care system learn how to access care, but there have to be trained case managers to do so," she says.

Case managers in physician offices will be involved in coordination of care, transition of care, and everything else they're involved in now, but they're likely to be doing it with a larger caseload, Mullahy says.

Preventing hospital readmissions, another hot topic, presents another opportunity for case managers because of their role in transitions in care, Leonard adds.

CMSA convened the National Transitions of Care Coalition, which brings together the major players in the health care arena to develop ways to transition patients safely through the continuum of care.

When people are discharged from the hospital to a post-acute provider, then home with home care services, someone must coordinate their care to make sure that each level of care has the information it needs to provide the services that patients require, Leonard points out.

The primary care physician who sees the patient for follow-up after the hospital discharge also needs to know what happened during the hospital stay. If patients are seeing multiple specialists, someone has to be responsible for ensuring that each clinician knows what the other has determined and prescribed and that the patient is receiving coordinated care.

All of these tasks fall into the case management arena, Leonard points out.

"We already have the training and skills for all of the care coordination that health care reform is going to make essential," she adds.

When health care reform kicks in, physician offices will need more case managers to coordinate care for their complex patients, Mullahy points out.

There will be a need for more case managers to help the influx of beneficiaries on Medicaid learn to navigate the health care system, she adds.

On the payer side, insurance companies are going to need more case managers to ensure that patients receive the most effective and efficient care, Leonard says.

"We went from population disease management and sending out educational information to telephonic case management. Now, payers are developing tools to identify members who benefit from one-on-one case management in an integrated model that combines both behavioral health and medical management. We are moving toward more one-on-one care coordination in the hope that it makes people's lives better and reduces the cost of care," she says.

There also will be opportunities for independent case managers who contract with individuals, attorneys, or insurance companies on a case-by-case basis once there is a payment mechanism in place, Leonard adds.

To avoid losing reimbursement if patients are readmitted, hospitals will have to have care coordinators who work with patients after discharge to make sure patients have follow-up visits with physicians and follow their treatment plan, Leonard says.

She predicts that home care agencies will provide more care coordination to ensure that the primary care physician has information about the patient's home care episodes and vice versa.

"There is a great deal of opportunity for case managers. The medical home model is all about care coordination. Providers are going to have to have someone who is responsible for coordinating with other providers and services to make sure that patient gets everything he or she needs," she says.

But with the opportunity comes the challenge of making sure that people who are called case managers actually are performing the case management role and that people who move into the role have the kind of education they need to do the job, Mullahy adds.

"Employers in every practice setting seem to think that if you're a nurse or social worker, you can be a case manager. We need to make sure that

people who are acting as case managers understand the role and all that it entails," she says.

"The stimulus package will have to include additional money for scholarships to train more nurses, but if they finish school, they definitely will have a job," Leonard adds.

The need to education clinicians on care coordination will lead to opportunities for case managers in the academic world where they can share their skills with people in other disciplines who want to become care coordinators, Leonard says.

She predicts that all health care disciplines will receive some basic training in care coordination, case managing, and motivational interviewing.

"The multidisciplinary curriculum will be for pharmacists, social workers, and therapists as well as nurses. We're talking to some schools now about this possibility. Case managers will have the opportunity to be instructors for these programs, or to train the trainers," she says. ■

Care coordination for Medicaid high-users

Program integrates, mental health, medical, issues

Medicaid recipients who are "frequent fliers" are getting help with their medical, behavioral health, and psychosocial needs through a pilot project developed by Hudson Health Plan and the New York State Department of Health.

The Westchester Cares Action Program demonstration project targets the state's highest-utilizing, highest-cost Medicaid recipients who receive fee-for-service medical care.

Westchester Cares Action Program provides face-to-face and telephonic care coordination for people in the project and receives a monthly fee from the state.

After the three-year project is completed, the state will compare the Medicaid beneficiaries in the Hudson health care pilot project to a control group to determine if there are cost savings and share the savings with the health plan.

The program integrates mental health, medical issues, and psychosocial issues and works to help participants overcome the barriers to improving their health, says **Margaret Leonard**, MS, RN-B, C, FNP, senior vice president for clinical services at Hudson Health Plan, a Medicaid managed care plan with headquarters in Tarrytown, NY.

"These are the most expensive patients on the state Medicaid rolls. From our experience as a payer, we believe that once we get these people stabilized and address their psychosocial issues as well as medical and mental health needs, we can make a big difference to them," she says.

When the program went live in August 2009, the state of New York gave the health plan a list of 250 Medicaid recipients with their last known addresses and telephone numbers, when available. The people were identified through an algorithm developed with New York University. The algorithm stratifies the beneficiaries and predicts their likelihood of needing services.

About 90% of the telephone numbers were incorrect or had been disconnected. Some people on the list were off the Medicaid rolls, had lost their eligibility, or enrolled in another program that made them ineligible for the Westchester Cares initiative, Leonard says.

Among the potential participants, 100% have chronic medical conditions, 75% have mental health and medical conditions, 72% have medical, behavioral health, and substance abuse issues, and 39% are homeless.

"Finding them has been very challenging. This is a transient population, and many of them use disposable cell phones so we don't have current telephone numbers for them," Leonard says.

The health plan contacts neighborhood shelters, clinics, halfway houses, soup kitchens, and other community organizations for assistance in locating the targeted beneficiaries.

Eight months after the pilot project went live, the health plan had located and enrolled about half of the 250 beneficiaries on the list provided by the state.

Finding the beneficiaries a second time is also a challenge, Leonard says.

"Sometimes they make an appointment and the person isn't there. Sometimes we never can reach them again," she says.

The project is staffed by nurses; social workers; intensive care coordinators, who are bachelor's-prepared, non-licensed people; and peer support specialists, people from the community who have been through the Medicaid system and understand the challenges of the people in the program.

The health plan held kick-off breakfasts at a local outreach program, shelters, and clinics to explain the program and recruit candidates for the intensive care coordinator and peer support specialists.

"We received a number of recommendations through the community-based organizations," Leonard says.

The intensive care coordinators make outbound telephone calls in an attempt to locate the people on the list or go to the beneficiaries' homes to look for them and enroll them in the program. Beneficiaries who enroll get a $20 gift card.

The intensive care coordinator sets up an appointment for a clinician to meet with the beneficiary and completes a comprehensive assessment within 15 days of enrollment.

"The staff go out in pairs for safety reasons. The nurse may go with the care coordinator, social worker, or peer support specialist," Leonard says.

The nurse enters the assessment into a computer program that includes an integrated health assessment tool.

The software analyzes each participant's areas of concern and outlines where the team should concentrate first, whether it's economic issues, psychosocial problems, mental health issues, or medical conditions.

Most of the time, team members have to work on solving financial and psychosocial problems before they can even start to look at the health problems of the beneficiaries, Leonard says.

"Coordinating care and making sure these beneficiaries follow their treatment plan is a tremendous challenge because there are a lot of psychosocial barriers. You can't get somebody to test their blood sugar every day or to take their medication regularly when they're shooting up, worried about their child, or homeless," she says.

Take for example, a beneficiary who was living with her unmarried daughter and her daughter's two children. The daughter stabbed the mother's boyfriend and was arrested. Under New York law, she was facing eviction from public housing because of the arrest.

The health plan intervened to keep the family in their home.

"We have to deal with issues like these before we can start on disease management. We've done a lot of things in this program that we've never done before. We've found housing for people; we've gone to court with them, or talked to their landlord about providing heat," Leonard says.

The case manager identifies what problems the participant faces and develops a care plan that encompasses his or her psychosocial, clinical, and mental health needs, then works with the participant to establish goals that are reachable, Leonard says.

For instance, keeping the blood sugar at a certain level is too difficult a goal in the beginning and would be overwhelming to the patient. Instead, the case manager will suggest daily monitoring and taking medication.

"Depending on what they decided, the case manager may follow up later in the day to make sure the participant did the things they decided on," she says.

The nurse or social worker and the intensive care coordinator work as a team and plan how to divide the work in coordinating care for the client.

If an intensive care coordinator has signed up a person, he or she will continue to be the main contact for the person and coordinate with the nurse. The team meets daily to discuss the patients, their progress, and what they need.

The team checks all medications the participant is taking and educates him or her on how to take them. The plan is to connect the participants with a medical home and help them follow their treatment plan.

Sometimes, a team will accompany patients to see the doctor for a physical therapy session or to the hospital. They have gone to the housing authority or to court with people who needed help in solving their social problems.

They provide transportation to doctors' offices whenever needed, teach the clients how to pay bills, and educate them on having a healthy diet.

They work to arrange housing for the homeless and to get addicts and alcoholics into treatment programs and support groups.

The intensive care coordinators make regular calls to the beneficiaries to ensure that they are taking their medicine and to make sure they don't need any additional assistance.

"This gives the participant someone else to talk to if they have questions and concerns. They can call into the program and talk to their case manager if they are having health problems or feeling anxious, and the case manager can make arrangements to see them the next day," she says.

The medication adherence piece and giving the participants someone they can talk to are keys to the success of the program, Leonard says. "We do a lot of hand-holding in this program, but these people have had a hard life. They don't know the system and need help finding ways to get their needs met," she adds.

It's too early to have definitive data, but anecdotal evidence shows that emergency department visits and hospitalizations have declined dramatically among participants.

For instance, two participants who were fre-

quent utilizers of the health care system had just one hospital stay and two emergency department visits between them after participating in the program for seven months.

Hudson Health Plan's administration has been so impressed with the pilot project that it is launching a similar program to provide care coordination for eligible Hudson Health Plan members in its managed care programs.

In that program, the complete care program, nurses, social workers, and clinical assistants work with high utilizers to meet their psychosocial, mental health, and health care needs. ■

Workers' comp: Getting the devil out of the details

Show employer how much they would save

Trying to determine exactly what drives your biggest workers' compensation costs? The devil is in the details.

"You should look not only at the types of injuries you are having, but where they are occurring, the departments, supervisor involvement after the accident, and follow-up care for the injured worker," says **Mary (Penny) B. Nicholls**, RN, CCM, COHN-S, a disability consultant with Alabama Power Company in Birmingham and a member of the advisory board for the Deep South Center for Occupational Health & Safety at the University of Alabama at Birmingham.

To reduce worker's compensation costs, do these four things:

1. Do a thorough evaluation of individual job tasks to identify associated risks or hazards.

"You cannot be effective in delivering care to workers if you are not knowledgeable about specific work processes," says **Kathy Dayvault**, RN, MPH, COHN-S/CM, an occupational health nurse at PureSafety in Franklin, TN. "Be familiar with their potential or actual impact on workers."

Do a walkthrough at regular intervals and observe employees doing their jobs, accompanied by a safety professional, industrial hygienist, or member of management. "This helps you to learn about job concerns from a different perspective," says Dayvault. "An interdisciplinary team is essential in risk or hazard identification and reduction."

She points to research showing that back strain injuries in health care workers, and workers' compensation costs, were decreased after safe movement programs were implemented.[1] "This type of program is a good example of a safety program which focuses on specific job risks," says Dayvault.

2. Obtain statistical data regarding injury type, department, frequency of injuries and reoccurrence.

Once you have this information, associated costs with injuries can be provided by the workers' compensation carrier or in-house claims adjuster. This information can identify areas of high injury rates.

"The carrier can provide a historical overview of injuries. This is important because it is the justification to make a change that might be considered costly," says Dayvault. "You can show the employer how much they would potentially save in the future if the change is made."

3. Learn as much as you can about the injured worker.

Nicholls says that in order to understand hidden workers' comp drivers, you must understand the injured worker's past medical history, social factors, and work environment. Learn about job dissatisfaction, interpersonal conflicts, the type of work he or she does, lack of upward mobility, and physical stressors.

"All of these will affect the response to medical treatment, either overtly or covertly," says Nicholls. "The more we know about our injured worker, the better we can control the medical treatment plan. Thus, there will be better outcomes, in both cost and recovery to maximum medical improvement with little or no impairment rating."

4. Don't overlook the cost of litigation.

"We can all compare our case costs with the Official Disability Guidelines predicted values and say what a good job we do when we are well below on visit frequency, physical therapy and diagnostic testing," says Nicholls.

However, the real costs are revealed when the final outcome for the worker is not as good as the statistics indicate they should be. If a lawsuit occurs, costs will take a significant hit.

"Rarely are the true costs of litigation captured under workers' compensation costs, but these should be," says Nicholls. "Many times, these costs are near the cost, or may exceed the cost, of medical treatment. "

For this reason, your efforts are best spent on developing a process to optimize work injury management that will meet everyone's needs. "The

Rewarding workers for lack of injuries is risky

Have you learned that back injuries are the top cost drivers in workers' compensation cases at your workplace? Imagine the impact of giving incentives to various departments if zero injuries are reported within a certain time period. Or then again, maybe not.

"Not reporting injuries, especially cumulative trauma injuries, is not a good approach. If workers are pressured not to report injuries, they may defer reporting until the pain is so bad that treatment ends up being more involved," says **Eileen Lukes**, PhD, RN, COHN-S, CCM, FAAOHN, a Mesa, AZ-based member of the American Association of Occupational Health Nurses' board of directors. "A simple first-aid injury could instead become recordable and maybe even a lost-time case." This is particularly dangerous for cumulative trauma injuries, she adds.

Incentive programs for decreased reporting of injuries are counterproductive, since these don't address unsafe working conditions, says **Kathy Dayvault,** RN, MPH, COHN-S/CM, an Occupational Health Nurse at PureSafety. "Be careful when instituting incentive programs such as these. It can appear that the responsibility of injury prevention belongs to employees, not employers," warns Dayvault. Use these approaches instead:

• Make minor, low-cost changes.

For example, if items are raised off the floor so they can be lifted from an easier working height, back injuries may be reduced. "Methods such as these are simple and do not cost a lot of money," says Dayvault.

• Reward employees for reporting unsafe work practices.

"This is much more effective at improving injury/incidence rates than rewarding decreased reporting of injuries," says Dayvault. Employees could be given incentives for calling attention to a coworker performing an unsafe act, such as driving a forklift too fast or turning blind corners and not blowing the horn, for example.

"Reward employees for following safety rules, or for giving suggestions to make a task or process safer," says Dayvault. "Spotlight employees in a company newsletter for raising safety awareness."

Lukes recommends insisting that managers be evaluated on incorporating safety and prevention in their annual business goals. "Reward safe behaviors like pre-workday stretching," she says.

• Use a team approach.

"This is more effective than trying to make changes independently," says Lukes. "Sitting down with management and safety to discuss trends and costs will increase buy-in from others. When the nurse presents the data, the solution may be self-evident."

Meeting with teams of employees is another way to come up with effective solutions. "After all, they're the ones doing the work, so they may be in the best position to figure out what needs to be changed," says Lukes.

• Implement an ergonomic program which addresses cumulative trauma injuries.

"When partnered with design change and ergonomically correct tools, not only can ergonomic injuries be reduced, but eradication can occur as well," says Dayvault. ■

establishment of this type of process will reduce worker's compensation litigation and costs," says Nicholls.

However, Nicholls says that the real benefits of a successful resolution of an injured worker's case can't be measured in dollars. That's because the worker will become the company's best spokesperson after being treated fairly.

"The impact of a successful outcome on the injured workers is so great that the value cannot be truly measured," says Nicholls.

REFERENCE

1. Sedlak CA, Doheny MO, Jones SL, et al. The clinical nurse specialist as a change agent: reducing employee injury and related costs. *Clinical Nurse Spec* 2009:23(6):309-313.

[For more information on collaborating with safety, contact:

Kathy Dayvault, RN, MPH, COHN-S/CM, Occupational Health Nurse, PureSafety, Franklin, TN. Phone: (615) 312-1242. Fax: (615) 367-3887. E-mail: kathy.dayvault@puresafety.com

Mary (Penny) Nicholls, RN, CCM, COHN-S,

Use team approach to ID workers' comp costs

Consider yourself a member of the "workers' compensation team" as a strategy to reduce costs, says **Mary (Penny) B. Nicholls**, RN, CCM, COHN-S, a disability consultant with Alabama Power Company in Birmingham and a member of the advisory board for the Deep South Center for Occupational Health & Safety at the University of Alabama at Birmingham.

In addition to the occupational health professional, other "players" may include the injured worker, employer, safety professional, health care provider, case manager, insurance adjusters, attorneys and vocational rehabilitation specialist. She gives these recommendations:

1. Work with safety professionals to investigate early and thoroughly.

"Tie the facts down early, as it may take years to come to court," says Nicholls. She says you should:

- Identify mechanisms of injury, and relate this information to the health care provider.
- Determine whether the condition was causally related to the work or job.
- Determine whether the injuries were sustained during an unreasonable or substantial deviation from employment and not compensable.

2. Work collaboratively with health care providers to assess causality, provide physical capacities, expedite care, communicate with patient, family, and company and coordinate care with other health care providers.

"The health care provider must ask whether there was a clear, probably traumatic event, to assess the mechanism of injury. Are the symptoms consistent with the source of injury, or are they due to repetitive stress which is more difficult to identify?" asks Nicholls. "They must also determine if it is pre-existing, a reoccurrence, acceleration, an exacerbation, or an aggravation This determination is a cost driver within itself."

3. Convey to injured workers that you care about them.

"A trust begins to build and the results will be greatly improved," says Nicholls. "History shows that injured workers who feel truly cared for do not sue their companies. This will result in cost control, even though it is not disease-specific!" ■

Birmingham, AL. Phone: (205) 257-3327. E-mail: MNich71885@aol.com.

Eileen Lukes, PhD, RN, COHN-S, CCM, FAAOHN, Mesa, AZ. E-mail: enlukes@cox.net.

Emily Wallace, RN, BS, COHN-S, Occupational Health Consultant, Sanford, NC. E-mail: wwallace7@charter.net.] ■

Is wellness data too dismal to share? Don't be so sure

Even "bad" numbers can help you

Imagine showing higher-ups statistics indicating that thousands of dollars were spent on a weight loss program you implemented recently, but unfortunately, none of the participants actually lost any pounds. Or would you be eager to spread the news that only two employees attended a diabetes lunch-and-learn?

Unfortunately, data don't always tell the story you'd hope for. "Poor attendance at a wellness program is not uncommon, even when you do everything imaginable to publicize the event," says **Eileen Lukes**, PhD, RN, COHN-S, CCM, FAAOHN, a Mesa, AZ-based member of the American Association of Occupational Health Nurses' board of directors. "Or, few employees may participate in a physical activity challenge."

Since these "disasters" are all too common, Lukes says that occupational health managers need to "learn the art of making a silk purse out of a sow's ear, and emphasize the positive." Use these approaches:

- **Even if participation is poor, always ask participants to evaluate the program.**

This way, you can tell others that 95% of the participants said that they learned something new, or 87% said they are committed to eating more fruits and vegetables in their daily diet, says Lukes.

- **Remember that even a single participant counts.**

If even one person gets their blood pressure

under control or quits smoking, there's a pay-off in reduced health care costs. "The professional literature is full of information about the cost of poor lifestyle choices," says Lukes. "So for every single success, even if it's just three people, a cost-benefit can be calculated."

• Don't give up just because participation is less than expected.

"This should not be the signal for nurses to give up their health promotion efforts," says Lukes. "Rather, they should analyze why employees didn't come." Address those reasons when developing your next event or program.

• Ask for incentives if you think it would help participation.

Research clearly shows that employees respond to incentives, so use this to your advantage. "Poor participation in a health screening provides ammunition to seek greater executive support in the future," says Lukes.

• Ask managers to participate.

Market wellness events to upper management. "If management does not participate, they provide a subtle message to employees that the program is not worth attending," says Lukes. "Enlist them to serve as role models and champion important health promotion efforts." ■

PAPRs end frustration of fit-test failures

Hospital diverts funds to reusables

At DuBois (PA) Regional Medical Center, employees were failing N95 fit tests in alarming numbers. In the cardiology department, about 46% of employees failed fit-tests — even after trying a variety of models and sizes. Things weren't much better in anesthesia (35%), cardiovascular ICU (34%), or the emergency department (26%).

The most important number — the one that prompted the hospital to switch to powered air-purifying respirators (PAPRs) — was the cost: about $37,000, mostly in loss of productivity of clinicians who had to spend an average of 35 minutes to complete a fit-test.

By comparison, the investment in PAPRs and education cost about $38,000, including about $5,000 for education — the only annual cost.

"We were investing a significant time commitment and money every year, and the [fit-test] failure rates were higher than we were comfortable with," says **Sue Miller**, RN, COHN-S/CM, director of employee health at DuBois.

Fortuitously, DuBois made the transition to PAPRs in 2008, a year before hospitals were faced with the novel H1N1 strain of influenza. That reinforced the benefits of reusable respirators, as the hospital avoided the scramble for supplies and massive fit-testing efforts.

"For us, it was a good return on investment. It made our life so much easier during the crisis," says Miller. "I'm definitely very happy we went with this solution." ■

COMING IN FUTURE MONTHS

- Integrated case management puts employees back to work
- Coordinating care among the patient, provider, and payer
- Ensuring that patients who need it receive palliative care
- Helping seniors stay safe in their own homes

CE QUESTIONS

21. Hunter Ramseur, MEd, LPC, CDMS, ATP, suggests it is more effective for clients to learn how to use assistive technology in the home environment.
A. True
B. False

22. The pilot project developed by Hudson Health Plan and the New York State Department of Health will last how long?
A. one year
B. two years
C. three years
D. four years

23. Which is true regarding efforts to reduce workers' compensation costs?
A. The injured workers' past medical history and social factors can help you to understand hidden worker's compensation cost drivers.
B. Litigation costs should never be considered as part of worker's compensation costs.
C. Factors such as an injured worker's job dissatisfaction are not relevant.
D. Incentive programs for decreased reporting of injuries are effective, especially for cumulative trauma injuries.

24. Kathy Dayvault, RN, MPH, COHN-S/CM, says incentive programs for decreased reporting of injuries are counterproductive, since they don't address unsafe working conditions.
A. True
B. False

Answers: 21. A; 22. C; 23. A; 24. A.

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.

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 this issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■