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## IN THIS ISSUE



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# Initiatives reduce readmission rates for Medicare Advantage members

*Health plan partners with hospitals, PCPs*

After two successful pilot projects aimed at reducing readmission rates, Capital District Physicians' Health Plan Inc. (CDPHP) has implemented a program aimed at ensuring that its Medicare Advantage members get the care they need after discharge to avoid a return trip to the hospital.

The pilot projects produced significantly improved readmission rates, dropping from an average of 13% to 14% for members in CDPHP's Medicare Choices plan to an average of 6% to 8% for patients in the pilot, according to **Kirk Panneton**, MD, medical director of senior services at the Albany, NY-based health plan.

"When our Medicare members are admitted to the hospital, we partner with the hospitals and the primary care physicians and follow the patient to their home to make sure their medication is reconciled and that they get back to see their primary care physician in less than seven days," he says.

The readmission rate nationwide for beneficiaries with fee-for-serve Medicare is 20%, while it's 15% on average for people who are in Medicare Advantage programs, Panneton points out.

"Right off the bat, Medicare Advantage plans touch people more effectively to keep them out of the hospital. At CDPHP, we offer more than most Medicare Advantage programs and provide more support and education to help prevent readmissions," he says.

The health plan's readmission prevention program, which began in July, "takes the best elements of both pilot programs," Panneton says.

In one pilot, the health plan placed RNs, called inpatient care coordinators, in local hospitals to assist the hospital-based case managers in coordinating care for all CDPHP members.

When a Medicare Choice member in the pilot project was going home, the inpatient care coordinator alerted the health plan's case managers, who called the primary care physician to arrange a follow-up appoint-

ment within seven days.

In the other pilot project, the health plan arranged for visiting nurses to see patients in the hospital and introduce themselves, then followed up within 24 hours after the patient was discharged. When the nurse visited these patients after discharge, he or she examined all the medications the patient was taking, evaluated the patient for care needs, and helped set up a follow-up appointment with a primary care physician.

For the pilot projects, the health plan focused on patients who received primary care at several big medical groups in the area with no regard to diagnosis.

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"In the pilots, every Medicare Choice member who was chosen to participate received the services regardless of diagnosis. Going forward, we're going to provide the follow-up services for patients who can most benefit," he says.

The vast majority of Medicare members who are hospitalized have heart failure, chronic obstructive pulmonary disease, or coronary artery disease, Panneton points out.

The program focuses on patients with those three diagnoses and any others who the health plan's onsite inpatient care coordinators feel could benefit from the program.

For instance, a patient with a fractured hip may not need follow-up care unless he or she has limited support at home, has several chronic diseases, or is taking multiple medications.

The new program combines the best approaches from the two pilot programs, Panneton says.

While the new program will cover all lines of business that CDPHP serves, the majority of members served will be within its Medicare population.

Members identified for the program will be seen by a nurse in the hospital, then receive a home visit from a nurse within 24 hours of discharge.

The home visit part of the program strives to reconcile medications, ensure that care needs are being met, and schedule a follow-up appointment with the patient's primary care physician. The nurse will then conduct a follow-up call seven days later to ensure that these processes, and the patient's recovery, remain on track.

Before the pilot projects began, representatives from CDPHP met with representatives of the hospitals in their area, the visiting nurse organizations, and primary care group practices to educate them about the project's goals and to get their buy-in.

"Everybody in health care is trying to reduce readmissions, but those who are the most successful are those that are collaborating with other organizations. When the payer, the hospital, and the primary care provider come together, they are able to make a program happen," he says.

It's a win-win situation for everyone, Panneton says.

"Hospitals have an interest in reducing readmissions because they aren't going to get paid. The visiting nurse agencies are anxious to get more business. The providers are willing to participate because we are giving them extra reimbursement for seeing patients within seven days of discharge," he says.

Capital District Physicians' Health Plan was

started 26 years ago by a community of physicians in the greater Albany area, according to **Kevin Mowll**, vice president of Medicare products.

The health plan has about 25,500 members enrolled in its Medicare Choice program, a Medicare Advantage plan. The figure includes about 8,000 retirees who are part of an employer group, Mowll says.

CDPHP expanded its Medicare case management program when Panneton, a physician with years of experience in geriatric medicine, came on board in June 2008.

"At the time, we had only one case manager dedicated to our Medicare population. As the membership has grown, we have expanded the program and now have six case managers dedicated to Medicare beneficiaries," Panneton says.

The health plan created the CDPHP Health Ally program, a voluntary case management program for the health plan's Medicare Choice members and their caregivers, Panneton says.

The program was developed specifically for the Medicare population and takes into account the unique needs of that population and provides support, education, access to the health plan's benefits, and community-based services, he adds.

The health plan makes three outreach calls to Medicare Choice members shortly after their enrollment.

When members enroll in Medicare Choice, they receive a verification call from the health plan's outreach staff to make sure they understand the plan. When they become eligible, the outreach staff call again to walk them through the benefits and ensure that they understand what benefits are available to them, Mowll says.

The third welcome call is from a case manager who completes an assessment that stratifies the members into three groups based on their likelihood of using health care services, Panneton adds.

"Our Health Ally program is designed to touch all new Medicare members by the telephone and to conduct a brief health survey," Panneton says.

Based on their response to the health survey and probability of needing health care resources, the members are referred to health plan programs that can meet their needs.

Members who are fairly healthy are referred to the health plan's SeniorFit program, a free health, exercise, and wellness program for older adults.

Seniors with one or two chronic diseases, such as a diabetic with hypertension, are referred to disease management, where they receive education on their chronic condition and how to keep it under control and are encouraged to see their physician regularly.

About 5% to 10% of beneficiaries in the program are among the most frail and sick members and are assigned a case manager who contacts them regularly and offers support and counseling and helps them find resources to meet their needs.

"Our case management program has grown significantly, and our Health Ally program has helped us stratify the members and help them get the services they need," Panneton says.

The advantage of the Health Ally program is that CDPHP is able to identify the needs of members without waiting for claims data, Panneton point out.

"If we wait for claims to come in, we are always three to four months behind. Our program helps us find out more about the membership when they enroll and start working with them to help them avoid unnecessary hospitalizations and emergency room visits. Our case managers work with our members to help them keep their conditions under control and educate them so they can make informed decisions," he says.

"The Health Ally program was a big strategic move to meet the challenge of finding out more about the membership so we can take a proactive approach to help them manage their health care," he says. ■

# Oncology CMs guide patients through treatment

*Program helps with symptom management*

Capital BlueCross members who have been diagnosed with cancer are getting support during all phases of treatment through a new oncology case management program launched in the spring of 2010 by the Harrisburg, PA-based health plan.

The health plan added oncology case management to its specialty case management program after determining that 20% of the patients receiving case management services have a diagnosis of cancer, says **Jennifer Chambers**, MD, MBA, FACP, medical director at Capital BlueCross.

"Patients with a diagnosis of cancer have a unique set of issues. When they hear the word 'cancer,' they tend to shut down, and when they come out of the doctor's office, all they remember is that they have cancer. We created this program

to support them during this challenging time," she adds.

The case managers who work with cancer patients are nurses with extensive case management, home care, and/or oncology experience. They work with Chambers, who is board-certified in internal medicine and palliative medicine, to coordinate care for patients who have been identified through hospital admissions, referrals from physicians, and self-referrals.

The purpose of the program is to help members and families work through difficult issues such as treatment options, symptom management, and life-care planning, Chambers says. Case managers are trained to help patients understand their disease and their treatment options. They help them access educational resources such as the American Cancer Society and the National Cancer Institute and assist them in compiling a list of questions they should ask their doctor at their next appointment.

"We know from evidence-based data that there are five domains where case managers can make a difference: empowerment, adherence and compliance, coordination of care, knowledge, and safety," Chambers says.

Empowerment is the portal to all the other domains, Chambers says.

"When members are educated and understand their treatment plan, they start to feel a sense of control. They may not be able to control the cancer, but they can control when and where they receive treatment, when to make the decision about palliative care, and who to see for a second opinion. We want members to feel educated and informed," she adds.

Patients undergoing cancer treatment often are treated by multiple physicians, including a surgical oncologist, a medical oncologist, and a radiation oncologist, as well as their primary care physician, Chambers says.

Case managers often coordinate with the various treating physicians to make sure they are fully informed about other treatments the patient is receiving, and attempt to coordinate times and arrangements for numerous medical appointments.

They also may consult with treating physicians to advise them of concerns or challenges voiced by patients.

"A primary goal for case managers is to help patients navigate through the health care system and feel more comfortable in making decisions with their doctors. We don't make treatment decisions for the members; we help the members with questions they need to ask to make the best decision for them," Chambers says.

They address safety issues with patients, such as whether they have someone to provide transportation or assist with care at home. They advise them on how to prevent infection and suggest overall ways they can improve safety in the home.

Once patients say they are interested in participating in the program, the nurse case manager completes an assessment to identify the patient's needs and helps him or her develop individual goals and plans.

The case managers base their interventions and frequency of follow-up on the needs each member identifies.

They make periodic calls to check on the patients' progress and work closely with the patient and the treatment team to address any concerns or questions.

"We find these phone calls are very helpful because they provide a sense of confidence and empowerment for the member. They ask the patients about their goals and what they need to accomplish them. The case managers listen to the patients and offer their support and encouragement," she says.

The case manager closes the case when the plan of care developed by the member and case manager is completed and no further needs are identified. If patients need further treatment or support, they may become actively involved in case management again.

During their interventions with the patients, the case managers encourage them to have advance directives in place.

When a patient's cancer progresses to the point that he or she needs palliative and/or hospice care, the case manager helps facilitate a discussion with the physician and gives the patient information about palliative care and hospice options and providers.

"Some patients never want hospice care. They want to continue treatment even if the cancer can't be cured. But they do want help with pain and nausea. What happens is always the choice of the member. If people are making a conscious decision not to have hospice care, the case managers help facilitate management of symptoms," Chambers adds.

The oncology nurses meet with their supervisor on a routine basis to discuss their feelings and experiences in dealing with patients with a life-threatening disease.

"The case managers are either experienced hospice nurses or oncology nurses, but they often need

support in coping with caring for terminally ill patients. They talk about when they are feeling sad and when they need to take a break and do self-care," she says.

The health plan team spent about nine months developing the program and ensuring that everything the participants will need was in place.

"We like to start working with these patients as early as possible or as soon as they're ready to participate," she says.

The health plan mines its claims data to identify patients who have been hospitalized with a primary or secondary diagnosis of cancer and makes an outreach call after the patients are discharged, following up with a letter asking if the patient would like to participate in the program.

"Some patients aren't ready to participate just after diagnosis. It's an individual decision. Our case managers are there to help them whenever they are ready for assistance," Chambers says.

Initial participants in the program range from patients who have just had surgery for cancer to those who are entering hospice, Chamber says.

"As the program progresses, we anticipate that we will be enrolling the majority of patients in the program much sooner in their cancer treatment regimen," she says. ■

# CMs ensure low-income women get follow-up

*Study shows 35% reduction in diagnostic delays*

Low-income women with abnormal mammogram results are more likely to receive appropriate diagnostic procedures in a shorter time frame when a case manager guides them through follow-up care, a study has shown.

The proportion of women experiencing a diagnostic delay greater than 60 days decreased from 33% to 23%, a 35% reduction, after the case management interventions were introduced.

"Case management to assist women in overcoming logistic and psychosocial barriers to care may improve time to diagnosis among low-income women who receive free breast cancer screening and diagnostic services," says **Rebecca Lobb**, ScD, MPH, of the Centre for Research on Inner City Health at St. Michael's Hospital, Toronto, and co-author of the report published in the March 22 issue of *Archives of Internal Medicine*.[1]

The median time from an abnormal mammogram to diagnostic reduction decreased by eight days after the case management program was implemented.

"Our study demonstrated that most of the women who participated in the program received follow up after an abnormal mammogram within the time recommended by Centers for Disease Control and Prevention [CDC] clinical guidelines," Lobb says.

The researchers studied 2,252 Massachusetts participants in the National Breast and Cervical Cancer Early Detection Program, which funds breast cancer screening and diagnostic services for low-income, under-insured women.

The women in the study were in a program administered by the Massachusetts Department of Public Health with funding from the CDC.

"The low-income population tends to experience multiple barriers to the early detection of cancer and timely follow-up. They have lower educational levels and don't usually have a regular health care provider. This population is culturally diverse, and often cultural beliefs factor into their failure to seek health care. The case management process provides women with support to reduce anxiety, coordinates patient-doctor communications, and reduces barriers to care," Lobb says.

The Breast and Cervical Cancer Early Detection Program is a screening program to make sure that eligible low-income, under-served, and under-insured women get breast examinations and mammograms. A case manager intervenes when a woman has an abnormal mammogram and ensures that she gets the appropriate follow-up, such as an ultrasound and/or breast biopsy, as recommended by her physician.

Beginning in July 2001, all Massachusetts participants with an abnormal mammogram finding were offered case management. In 2004, free breast cancer treatment was offered to eligible participants in Massachusetts through a Medicaid expansion program called the MassHealth Breast and Cervical Cancer Treatment Program. The case managers funded by the Department of Public Health Women's Health Network program helped the women apply for the free treatment, but often were not able to follow them through treatment, due to mandate restrictions, says **Mary Lou Woodford**, RN, BSN, MBA, CCM, care coordination program director for the Women's Health Network at the Department of Public Health.

In Massachusetts, the Department of Public Health does not provide direct services but con-

tracts with local organizations that provide the services, Woodford says.

To identify participants in the program, outreach staff throughout the state visited community-based organizations to inform them about the program and how they could participate.

"Their primary job was to educate community-based organizations about the program so that they could educate women in their respective communities. The regional outreach staff also provided education to providers in their regions so they could refer women who presented at the doctor's office without health insurance," Woodford says.

Organizations participating in the Women's Health Network program were primarily hospitals and community health centers. In rural areas, home health agencies acted as intermediaries and coordinators of the program by subcontracting with rural providers.

The case managers who worked with the women typically were employed by the hospital or the health center and took on the coordination of follow-up care as part of their regular duties.

"For most organizations, there wasn't enough volume for the organizations to hire a case manager on a full-time basis. In some cases a nurse case manager enrolled participants, determined their eligibility, and educated them in addition to coordinating care for the women with an abnormal finding," Lobb adds.

The program originally started as an early detection program, Woodford says.

"We funded 42 organizations around the state to do outreach and recruit women to enroll in the program. The case managers ensured that women who had an abnormal finding got follow-up exams, but that was where the program ended. It created a lot of angst for everyone because the case managers often couldn't follow the women through treatment," she adds.

After health care reform was passed in Massachusetts in 2008, the majority of women in the program had access to health insurance and no longer needed free care, prompting the department to look at a different way of providing services, Woodford says.

"Health care reform in Massachusetts ensured that a great number of people had access to health insurance for the first time, but just because they had insurance, they didn't necessarily get the examinations," she adds.

In spring 2008, the Department of Public Health launched a care coordination model, which gives funding to organizations to hire a multidisciplinary team to ensure that eligible women receive screening and follow-up care.

The new program includes two other CDC-funded programs — Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN), which screens women for cardiovascular risk and provides lifestyle behavior interventions to reduce their risk, as well as the Colorectal Cancer Control Program, which provides education and screening for colorectal cancer.

"Most of the funding that comes to the health department comes in silos. The Massachusetts Department of Health has worked really hard to develop and implement a program for women that eliminates the silos and focuses on the whole person," Woodford says.

For the new care coordination model, the health department contracted with primary care providers and gave them funding to hire community health workers to serve as patient navigators and clinical staff to serve as case managers to coordinate care.

"We knew that in order to meet the needs of a racial and ethnic diverse population, we needed people on the team who understood the culture and language of the population we served. We moved to a model that supported the community health workers as an integral part of the team," Woodford says.

Most of the RN case managers in the program are Caucasian and speak only English, while the community health workers have the same ethnic and cultural backgrounds as the community they serve.

"In the new model, we began to incorporate the community health workers as patient navigators, but when we surveyed the case managers, they reported that they were not utilizing the navigators, partly because they didn't understand their role and partly because they were uncomfortable about what the patient navigators were telling the patients," she says.

The initial role for the community health workers was to schedule appointments and assist the patients through the screening and follow-up process, but many times, they spent a lot of time translating for patients who didn't speak English.

"They weren't trained as medical translators, and they started to interpret things and advocate for the patient," Woodford says.

The department developed a 45-hour training course for the community health workers. The training includes how to communicate with patients, how to communicate with clinicians, con-

fidentiality issues, education on health topics, and medical translation challenges.

The case managers attended a 12-hour training course to educate them about what the community health workers were learning, cultural competency, health literacy, and team-building.

The training included education on the Case Management Society of America's practice guidelines that require them to complete an assessment and plan of care and monitor what happens, as well as education on appropriate breast cancer and cervical cancer follow-up guidelines.

Almost 20,000 women are enrolled in the program today, Woodford says.

"In the new model, the case managers' involvement doesn't stop once the person is directed to treatment. They stay with the people throughout the treatment regimen and work as a team with the community health workers, the providers, and the patients to ensure that the continuum of care is completed," she says.

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1. Rebecca Lobb, ScD, MPH; Jennifer D. Allen, ScD, MPH, RN; Karen M. Emmons, PhD; John Z. Ayanian, MD, MPP. "Case Managers Help Low-Income Women Receive More Timely Breast Cancer Diagnosis" *Arch Intern Med* 2010;170(6):521-528. Published online March 16, 2010 (doi:10.1001/archinternmed.2010.22). ■

# Compute $$ saved by *preventing* illness

*Prove their worth*

Preventing an illness or disease from happening in the first place may seem like "invisible" gains to many, but you don't have to settle for that. Instead, come up with figures to show the large dollar amount of savings that occurs by preventing just one costly diagnosis.

"We spend a lot of money on identifying disease when we really should be spending money preventing it," says **Linda K. Glazner**, DrPH, RN, COHN-S, CCM, FNP, FAAOHN, an occupational health consultant with Linda K. Glazner & Associates in Wausau, WI. "What I'd like to do is take some of the money spent on treatment and put it into primary prevention."

Coming up with impressive figures, which are readily available, can help you to do just that. Glazner gives the example of screening for colorectal cancer which can be done for about $1 a person. This means you can screen 25,000 employees for $25,000. "This is really dramatic, because the cost of the treatment is so expensive and prevention is so cheap," she says. "Also, the likelihood of finding at least one case is great."

In general, though, Glazner says that the results of "prevention are harder to show, and harder for the nurse to say 'I made the difference.' In the case of colorectal cancer, you can cite the cost from the time of diagnosis to the employee's return to work. This is much less if the condition is detected early."

## Prove the ROI

What is your biggest hurdle in obtaining resources for prevention programs? Often, it's proving the worth of those programs, according to **Brenda Schanhofer**, wellness coordinator at Miron Construction Co. in Neenah, WI.

"Saving money on purchasing or operations is easily quantified. Improving the wellness of your workforce can be tougher to prove," says Schanhofer.

Many times, a prevention program is forced to work with minimal resources in order to accomplish its goals. "This creates the question of where you should focus your time — accomplishing your goals or proving your worth and value within the company," says Schanhofer. "It is possible, and necessary, to do both."

Your programs, in order to be effective, must be supported by upper management and embraced by the company overall. "In regards to ROI for worksite wellness programs, we sometimes get too narrow in our scope of determining the success of a program by creating a 3:1 ROI," says Schanhofer. "But we need to look at the bigger picture."

That involves rewarding wellness versus treating illness. "This is an incredibly pro-active way to manage a worksite wellness program," says Schanhofer. "If you do that, the ROI will take care of itself over a period of time. Even a ROI of 1:1 is a successful outcome for this type of program."

She recommends using these approaches:

**• Look at worksite wellness as a long-term business investment.**

"It must be connected to company strategy, shared with employees, and supported by upper management," says Schanhofer.

**• Use certain measures to provide quantitative proof.**

For example, your wellness challenges can

provide statistics on weight loss, blood pressure, body mass and other biometrics. Weight loss is an easy way to gauge a successful wellness or fitness challenge, and as you begin to see results in the weight loss category, very likely you will see the same results in reducing high risk factors such as hypertension, high cholesterol, and even metabolic disorders such as diabetes and metabolic syndrome.

**• Obtain statistics from your health risk appraisals.**

"Determine the amount of lifestyle-related illnesses and the percentage of change over time," says Schanhofer. "This information will also give you targets for future programs."

*[For more information on obtaining resources for prevention, contact: Linda K. Glazner, DrPH, RN, COHN-S, CCM, FNP, FAAOHN, Linda K. Glazner & Associates, Wausau, WI. Phone: (715) 849-1776. Fax: (715) 849-2840. E-mail: glazner2@aol.com; Brenda Schanhofer, Wellness Coordinator, Miron Construction Co., Neenah, WI. Phone: (920) 969-7079. Fax: (920) 969-7393. E-mail: Brenda.Schanhofer@miron-construction.com.]* ■

# ID root causes of specific injury types

*Managing each case to closure*

Imagine being an occupational health nurse at a plant that had 10% of its workforce off work because of work-related injuries or illnesses. That was the challenge facing consultant **Patricia B. Strasser**, PhD, RN, COHN-S/CM, FAAOHN, principal of Partners in BusinessHealth Solutions in Toledo, OH.

"The overwhelming problem was upper extremity cumulative trauma disorders," says Strasser. "I worked with a team, and our approach was multifaceted."First, ergonomists were brought in to help with the root causes of the injuries. "A comprehensive ergonomics program was developed to 'stop the bleeding.'"

The plant did not have a return-to-work program, so a policy and comprehensive program was developed. "We began to return employees to transitional duty," says Strasser. "The program was critical with new cases, so that workers could remain at work. The nurse's role as case manager was critical to the ultimate success."

## Goals for each case

"Most importantly, we developed a workers' comp management team to manage *each* case to closure," says Strasser. "There were a lot of open cases." A goal was developed for each case, such as return to full duty or return to a permanent alternate job. The team worked diligently, meeting weekly, to realize the particular goal of each case.

"Fortunately, it was a state that allowed full and final settlements, as there were individuals who would never be able to return to the plant for various reasons, and settlement was the best option," says Strasser.

Strasser says that the simple answer to identifying cost drivers is "examine the data." Most workers' compensation insurers and third party administrators (TPAs) make a lot of data available to companies in standard reports, as well as through customized reports.

"The workers' comp 'loss runs' contain information that can help target strategies to deal with the costs," says Strasser. This can help you answer questions such as, "Are new cases or old cases driving costs?" "Does one plant or department have dramatically increased claims?" "Are costs due to a particular type of injury or illness?" "Are medical costs increasing more than industry norms?"

"The insurer or third party administrator is available to help examine the data to identify cost drivers," says Strasser.

*[For more information on identifying workers' compensation cost drivers, contact: Patricia B. Strasser, PhD, RN, COHN-S/CM, FAAOHN, Partners in BusinessHealth Solutions, Inc, Toledo, OH. Phone: (419) 882-0342. Fax: (419) 843-2623. E-mail: pbsinc@prodigy.net.]* ■

# Do you want to see back injury rates plummet?

*Find out underlying reasons*

Why is it that back injuries are one of the most costly and common worker's compensation injuries? "There are a lot of factors

associated with back injuries that create tough challenges," according to **Kathy Dayvault**, RN, MPH, COHN-S/CM, an occupational health nurse at PureSafety in Franklin, TN.

Dayvault points to research stating that three primary reasons for work-related injuries among health care workers are organizational factors, environmental factors and personal factors.[1]

"I believe all of these factors are relative to industry as a whole," says Dayvault. For example, not having adequate time, insufficient or inadequate equipment, fewer employers to adequately perform a task, and pressure to meet deadlines are examples of organizational factors.

Also, many types of industry have areas in their workplace with limited space, and lack the proper tools to adequately perform a job safely in these areas.

The researchers noted that the most common personal factor associated with a back injury is a previous back strain or injury. "This is a factor experienced across industry type as well as in healthcare occupations," says Dayvault. "When an aging workforce and the obesity epidemic are factored in, it is easy to understand some of the tough reasons behind the challenges in reducing injuries." She recommends these approaches:

**• Work with safety professionals to observe tasks.**

"This can be accomplished during a walk-through," says Dayvault. Identify tasks which include awkward positions, heavy loads and defective equipment. Then, identify jobs, tasks, or individuals at risk.

"Develop a strategy for effectively addressing each of these areas to reduce injuries, specifically back injuries," says Dayvault.

According to the U.S Bureau of Labor Statistics, in 2006, back injuries alone accounted for 21.2% of lost time injuries with days away from work.

"Through observing employees perform their job and understanding the impact of the job tasks on the back, a plan for intervention can be developed that meets workplace health *and* safety objectives," says Dayvault.

**• Get insight about the problem areas of the job from an employee.**

"It is important to have interaction with employees regarding specific jobs and tasks," says Dayvault. "Having conversations with both previously injured *and* non-injured employees about tasks can provide a wealth of information."

By having a conversation with previously injured employees, you can arrive at the root cause of a back injury. This may involve poor design, required productivity, or employees required to use inadequate or poorly kept tools.

"Understanding how specific injuries have occurred will help develop a strategy of prevention," says Dayvault. By interviewing employees who are currently performing the job, insight can be gained of how injury is avoided. This can help employees who currently perform a job associated with a high back injury rate.

"Through observing employees performing their job and understanding the impact of the job tasks on the back, a plan for intervention can be developed that meets workplace health *and* safety objectives," says Dayvault.

**• Use statistical data from the first report of injury, as well as diagnoses from health care claims and associated costs.**

It is best to use data from both resources, as back injuries may have occurred among workers who were hesitant or discouraged from reporting workplace injuries, Dayvault explains.

"Cost information is important to show upper management the impact of injuries on the bottom line," says Dayvault. "Having the ability to show return on investment speaks volumes. This may be necessary to bring about change." This is especially true if there are significant costs related to programs aimed at reducing back injuries.

**• Involve other professionals.**

Use other experts as your resources, such as ergonomists and other occupational health professionals. "They can assist with understanding the full impact of the task on the human body, as well as developing prevention strategies," says Dayvault.

Other members of the management team should also be included, especially if cost and workplace design are going to be impacted. "Physical therapists can offer insight in needs for work hardening programs to assist injured employees, or as an aid in reconditioning employees who have been absent for an extended period of time," adds Dayvault.

REFERENCE

1. Springer PJ, Lind BK, Kratt J, et al. Preventing employee injury: implementation of a lift team. *AAOHN J* 2009; 57(4):143-148.

*[For more information on prevention of back injuries, 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.]* ■

# Usability testing ensures clear info

*Make sure instructions can be understood*

Consider evaluating educational materials, such as an educational sheet, self-care instructions, or an informational website, with a usability test instead of a focus group, says **Dana Botka**, manager of customer communications with the Washington Department of Labor and Industries in Olympia.

According to Botka, usability testing is a tool for determining if an instructional piece follows the rules of clear communication. A focus group will give you reactions to the materials, explains Botka.

The communication problems Botka helps solve within a state agency are similar to those that occur within the health care industry. These problems might include a form on which customers tend to make repeated mistakes that have to be corrected, or a letter providing instructions that people find confusing and thus inundate staff with telephone calls. Her job entails training and mentoring groups of state employees who have business problems, because their customers misunderstand what they are trying to communicate.

Patient education managers know that health care costs rise when patients are readmitted to the hospital, because they did not follow the discharge instructions, or a patient's surgery is postponed, because he or she did not prepare adequately.

Usability testing can uncover the following:

- terms patients and family members don't understand;
- words that can mean something else;
- basic information or context that is missing;
- information that is unimportant and distracting;
- a patient or family member's emotional reaction to what was developed;
- the unexpected, or something the developer had no idea would happen.

When designing a piece, make sure the process is centered on the people who will use it, says Botka. To correct a document that is not working, gather a team of subject-matter experts together. As a group, gather around a projected laptop screen and work together to develop a clearer, more usable document, she adds.

"The most important step is the one that follows. The second step is to test the product, which may be a form or letter, with a representative sample of the real people who would use the document in real life," says Botka.

Taking a medical example, Botka explains that by creating user-centered design, post-operation instructions for cardiac patients would begin by considering the demographics of the patients who undergo the surgery. It is important to have the typical users clearly in mind when creating the document, says Botka. To make sure the piece is on target, it would then be tested with a representative sample of the typical audience.

To test the product, recruit four to six people who fit the description of your typical user, but who are not familiar with the material that is to be tested, advises Botka.

These people would be asked to come to a particular location for the usability test, and they would be scheduled at different times. Botka says offering money, or a gift card, provides incentive to follow through on the commitment.

Create a scenario that will allow the test participant to understand the situation. For example, for the post-op instructions for cardiac surgery, tell the participant that he is John Smith, a 56-year-old man who had a heart attack and underwent surgery three days ago. He is being discharged from the hospital with a set of instructions to follow.

Once the participant understands the scenario, he or she is given the instructions to read. Then, a series of questions prepared in advance are asked. These questions should be designed to get the person to do the tasks in the instructions, such as track daily sodium intake.

"If you want post-op cardiac patients to understand their diet, ask questions about that. You record the answers to see if they answer accurately, or see if they are missing something," says Botka.

Don't ask easy questions, she advises. For example, to determine if the medication instructions are easy to follow, ask what the patient's daily medication routine would be.

The test participants may use different words from those in the instructions, paraphrasing the information in their own words. This can give you clues as to phrasing the message, says Botka.

Also, in usability testing, you can use the "talk out loud protocol," which is to read a sentence or paragraph that you are concerned about and then ask the test participant to say

it back in his or her own words. This helps you know how people would actually say something, says Botka.

The solution to misunderstood instructions may not be plainer language, but a chart instead of a paragraph, or information may need to be explained so there is context.

"The easier you can make it for people to understand the steps required in the task, the more likely it is they will do it," says Botka.

Usability testing is particularly popular with Web design, adds Botka. It helps site developers determine if users can find information, and once they find it, if they can understand it. Also, if they can act on whatever task they need to do.

A survey or focus group does not test whether a person can do a task, says Botka. People will often say they "like" a document or website and yet not know how to use it. That's because they don't want to admit they had trouble or hurt the designer's feelings, explains Botka.

In addition, people may say they understand instructions, because they think they do; yet if asked to perform a given task, they are unable to do so, she adds.

"That is the advantage of a usability test; you get a better understanding of what people understand," says Botka.

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## COMING IN FUTURE MONTHS

- How home health services can prevent readmissions
- The latest trends in patient-focused care
- Helping patients identify a medical home
- Improving care for high-risk Medicaid members

# CE QUESTIONS

5. The readmission rate nationwide for beneficiaries with fee-for-serve Medicare is 20%. It's what percent on average for people who are in Medicare Advantage programs, according to **Kirk Panneton**, MD.
A. 10%
B. 15%
C. 20%
D. 25%

6. According to a study in the *Archives of Internal Medicine*, the proportion of women experiencing a diagnostic delay decreased from 33% to 23% after the case management interventions were introduced.
A. True
B. False

7. Researchers noted that the most common personal factor associated with a back injury is a previous back strain or injury.
A. True
B. False

8. Usability testing can improve an education piece by uncovering which of the following?
A. A user's emotional reaction.
B. Distracting information.
C. Words with dual meanings.
D. All of the above.

**Answers: 5. B; 6. A; 7. A; 8. D.**



## CE OBJECTIVES

After reading this issue, continuing education participants will be able to:
1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how the clinical, legal, legislative, regulatory, financial, and social issues relevant to case management affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities.

## CE INSTRUCTIONS

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