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

December 2010: Vol. 21, No. 12
Pages 133-144

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

Home visits support first-time moms through pregnancy, early childhood

Nurses help disadvantaged women turn their lives around

Jane McKinley, RN, BSN, loves her job because she knows she's helping vulnerable first-time mothers have a healthy first pregnancy and learn to be a good parent.

"It's a rewarding experience when you watch someone blossom into her own person and become a responsive mother who enjoys her life and takes good care of her child. That's the wonderful part about this job," she says.

McKinley is a nurse with Boulder County Public Health (CO), which has collaborated with the nurse-family partnership to implement a community-based program that follows families from early pregnancy through the child's second birthday.

The nurse-family partnership model provides face-to-face case management in the homes of pregnant women who often face the challenge of multi-generational poverty and multiple psychosocial issues. The Denver-based nonprofit organization partners with community organizations to replicate the program in local settings. *(For details, see related article on page 136.)*

"These families have lived in poverty for many generations, and that has a major impact on their ability to improve their lives. These young women don't have a lot of role models around them. We have clients who want to make a change, but the family group won't make a change," says **Nancy Kehiayan**, MS, RN, APRN-BC, associate nursing director at the NFP national service office.

Many times, the nurse from the nurse-family partnership is the first person who has been consistent in the client's life, she adds.

Randomized controlled trials of the program have shown increases in maternal health among participants, fewer pre-term deliveries, decreases in instances of child abuse and neglect, reductions in emergency department visits for accidents and poisonings, improved school readiness, and increased employment and reduction in the use of welfare and other assistance programs among mothers in the program.

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Not all families stay in the program for the full two-and-a-half years, Kehiayan says. Some leave for practical reasons. Others decide they don't want to continue.

"In the research projects, we found positive changes even in the families who were in the program only a short period of time," she says.

The program receives referrals from people in the community; the women, infants, and children program; community health centers; health care clinics; and community agencies, McKinley says.

"More and more frequently, women are referring themselves as other women in the program encourage their friends to enroll," McKinley says.

Full-time nurses typically work with up to 25 families at a time, she says.

"Some are clients who are on the verge of graduating from the program and who do not need the constant attention that people who have just joined the program need," she says.

The nurse-family partnership typically connects with the clients before the 28th week of pregnancy.

The nurses visit the families in their homes once a week for the first six weeks they're in the program, then every other week until the baby is born. When mother and infant come home from the hospital, the nurses visit weekly for four weeks, and then every other week until the child is 21 months old. Then they see the family monthly until the child's second birthday.

When she gets a referral, McKinley sends a packet of materials to the woman who has been referred, describing the nurse-family partnership and including her phone number.

Then McKinley calls her clients and makes an appointment to come to the home.

"There are situations when I can't reach the client, and in that case, I go back to the referral source for help in contacting them, she says.

Sometimes, in the beginning, clients don't feel comfortable meeting at their home and the first face-to-face meeting takes place at a library, a recreation center, or the nurse-family partnership organization's headquarters, McKinley says.

Over the first few weeks a client is in the program, McKinley works to establish rapport and earn the trust of the young mothers she works with.

"It takes time to establish a relationship. It doesn't happen in one visit. We focus on determining what challenges this mom and her family face and helping her overcome them," McKinley says.

The main goal of the program is a healthy pregnancy and healthy development of a child, McKinley says.

"We want to empower the mothers to become increasingly self-reliant so they can get the community care they need and take care of themselves in the world," she says.

When the nurses first meet with the mothers, they assess their psychosocial situation to determine what community resources they need to have a healthy pregnancy and take care of their child once they're born.

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

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

SUBSCRIBER INFORMATION

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

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

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

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

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EDITORIAL QUESTIONS

Questions or comments? Call Mary Booth Thomas at (770) 939-8738.

Editor: Mary Booth Thomas, (770) 939-8738, (marybootht@aol.com).

Executive Editor: Russ Underwood, (404) 262-5521, (russ.underwood@ahcmedia.com).

Managing Editor: Jill Robbins, (404) 262-5557, (jill.robbins@ahcmedia.com).

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They work with the women to develop healthy habits, such as eating healthy foods, stopping smoking and/or the use of illegal drugs, and keeping any chronic diseases, such as hypertension or gestational diabetes under control.

In the beginning, the nurses face the challenge of making sure the client's basic needs, such as food, housing, and utilities, are met. If they have a crisis situation, such as losing utilities or facing eviction, the nurses provide education and support and link the mothers with community resources and services, Kehiayan says.

The nurses do not perform physical assessments of the clients, although they do weigh the babies and make a cursory assessment of each baby's health during each visit.

"We don't let go of our nursing skills, but we don't want the client to think that we are the medical provider. Our job is to help them find the right kind of care and to use it appropriately," she says.

The nurses arrange for the women to receive prenatal care and make sure they have transportation to their appointments. They help the families get lined up with a primary care provider and help them make a list of questions to ask during their doctor's appointments.

"Our goal is to support our clients in using medical providers appropriately. Our area has a really good system of medical providers so if we walk into the house and the client or child looks sick, we stay with the client while she calls the clinic and arranges for someone to take them to the doctor's office," she says.

Because the Boulder area offers good prenatal care for indigent women, connecting women in the program with care providers isn't a big problem for the nurses in her area, McKinley says.

However, the majority of women face other psychosocial challenges that could affect their pregnancy and the child's well-being, she adds.

"As nurses, we are constantly assessing our client. When we work with clients in the home, we learn a lot of things about them that we wouldn't learn over the telephone or face-to-face in other locations. We can observe the home environment. Is it clean and neat or cluttered and crowded? We can see how they communicate with other people in the home," she says.

As they work with their clients, the nurses learn each woman's specific needs and empower her to access the community services that can help meet her needs, McKinley says.

"One of our biggest challenges is moving through some of the myths that are out there about pregnancy and child-rearing. The advantage of working with women who are pregnant for the first time is that they are eager to get as much information as possible. However, the program works because we have a close, personal relationship with clients. If we just gave them a manual to follow, it wouldn't be successful," she says.

McKinley anticipates problems the clients may have in staying healthy or providing for their child and works to overcome them. For instance, if she gives a client the number for a community service, she'll help the client make a list of questions to ask and offer to help her make the call.

"It's a matter of empowering them to act rather than doing it for them," she says.

After the baby is born, the nurses help the women transition to becoming parents and work hard to build a good and healthy attachment between parent and child, Kehiayan says.

As the child gets older, becomes more mobile, and starts to express his or her own will, the nurses work with the families to help them learn to encourage growth and development and to manage and work with the child effectively, she says.

"Our hope is that during this critical period, we can help the families learn skills that will carry them forward. There is a lot you can teach families during this phase about discipline and how to encourage growth and development of the child that will help as the child grows older. We work really hard to help the families understand the child as an individual and helping the moms and dads see things from the child's perspective," she says.

For instance, discipline is a challenge for young families with no role model, Kehiayan points out.

"We get the parents to talk about their own childhood and what they might like to have been different," she says.

On each visit, McKinley reviews with the mother what they discussed in the previous visit, what goals they set, and the mother's progress in reaching those goals.

"As a case manager working with these women, I often get two messages. One is that the client wants to make the change but the other is that she isn't following any of my advice or the plans we jointly developed," McKinley says.

In that case, she sits down with the client and reviews the plans they made over the last visit, answers any questions the client has, and develops a plan for the client to complete before the

next visit.

"Usually, the client didn't act because something else came up. When we review, we work together to come up with another plan," she says.

McKinley and the other nurses have a respectful attitude when they meet with their clients.

"If there are shoes by the door, I ask if they want me to remove my shoes. I always ask if there is a special place they'd like me to sit," she says.

The nurses are skilled in making sure the situation in the home is conducive to having a productive visit with the mother and child.

"I have no difficulty asking someone not to smoke in their own home or to turn off the television so there won't be any distractions. Sometimes there are other people watching, and I invite them to become part of the visit," she says.

The young women in the nurse-family partnership program face tremendous odds as they experience pregnancy for the first time and take on the challenges of raising a child, McKinley points out.

"Every person I meet has incredible strengths. I support their resilience and their capacity to care for themselves as much as I can," she adds. ■

Program aims to change kids' lives before birth

Helping young women develop parenting skills

The nurse-family partnership program focuses on first-time mothers because the first pregnancy offers the best chance to promote healthy behaviors, to building a bond between mothers and babies, and to teach the families positive child-rearing techniques, says **Nancy Kehiayan**, MS, RN, APRN-BC, nursing director at the NFP national service office.

The nurse-family partnership works with community-based organizations, such as health centers, hospital systems, visiting nurse associations, and faith-based groups that are already working with low-income populations. The local organizations adapt the model to fit in with the needs in their individual community.

Currently, there are nurse-family partnerships in communities in more than 32 states.

The nurses in the nurse-family partnership programs receive training in the national service office education center in Denver and go back to their agencies for more online training before they start working with clients. The program offers continuing education on a regular basis for all of the nurses.

The program employs nurse consultants who work with the program's local supervisors and help with any challenges or issues.

"We reinforce the education and provide clarity whenever it is needed," she says.

Nurses in the program need to be good problem-solvers with expertise in child health and mental health. They need to be able to work independently and have a passion for working with first-time moms, Kehiayan says.

Jane McKinley, RN, BSN, a nurse-family partnership nurse supervisor in Boulder, CO, has an office but adds "most of the time, my car is my office. It's filled with packs of information from other programs, developmental toys, baby scales, formal assessments, and ages and stages questionnaires."

Her organization has a weekly team meeting in which the nurses share their problems with clients and collaborate to find solutions.

"To work effectively with our clients, we have to know the resources of the community, and they are constantly shifting. This makes it important for all the nurses to work as a team and share case management information back and forth. In public health, we really rely on each other and expect that things will change. We work together and share our expertise," she says.

The nurses often bring up difficult cases and ask their peers for help in solving them.

"We use reflective consultation, which allows us to look at our experience of working with families. There can be situations that are very provocative but they may not be what we think they are," she says

For instance, one nurse case manager was working with a family where the infant was not gaining weight.

"When she observed the feedings, she became concerned that the mother was limiting the amount of food the baby was getting. She wanted us to help her come up with a plan on how to address the issue with the mother and whether an outside agency needed to get involved. In this case, she needed to make a report to social services because there was no medical explanation for the lack of weight gain," McKinley says.

The nurse was concerned that the mother would run if she was told that she was being reported to social services and that the baby would suffer.

"She was not clear about what to do. We helped

her think it through and make a decision based on what she knew about the client. She decided to tell the client that it was mandatory for her to call social services. This is an example of moving through your emotional reactions and doing what is best for the client and child," she says.

The organization takes great pains to ensure the safety of the nurses as they travel into disadvantaged communities, McKinley says.

The nurse-family partnership supervisor may advise that nurses avoid making home visits in certain neighborhoods after dark.

"We have a lot of basic safety rules, like not taking a purse into the house," McKinley says.

If nurses have any discomfort entering the home, they are prepared to tell clients that they can't see them today.

"Most of the time, the families are very protective of the nurse. If they are inviting me to the home, they are good about ensuring that it's safe. They may call and say it's not safe for me to come today or they may cancel the meeting or suggest that this time we meet at a different location," she says. ■

SW CMs free up RNs to assist members

Program takes care of clients' day-to-day needs

When people in financial hardship are worried about being evicted from their homes or don't know where their next meal is coming from, they aren't likely to remember to take their blood pressure medication or check their blood sugar levels on a daily basis.

That's why WellPoint started its community outreach initiatives, which include a social work care management program to help Medicaid beneficiaries get help with their day-to-day psychosocial needs.

"Because Medicaid beneficiaries face numerous challenges just to meet their everyday needs, our RN case managers were spending most of their time dealing with psychosocial issues like assisting with transportation to the doctor after a hospital visit, helping them access community resources, or getting them connected for mental health services, instead of working with clients on their medical health care needs, " says **Joyce Adams**, RN, CCM, MN, manager for case management for WellPoint's southern California region.

WellPoint's social work care management program received an honorable mention at URAC's Quality Summit and Awards Program.

The social workers help get the members connected to services to meet their psychosocial needs, freeing up the RN case managers to concentrate on helping members focus on their medical issues, she adds.

"Having social workers as part of the team brings a different professional expertise to the issues the members confront. When you support the Medicaid population, overcoming economic and social issues has to be tackled first before they can manage their health care," Adams says.

In a small pilot study, members who received interventions from social workers for just one month showed a 43% reduction in symptoms of depression, a 60% reduction in symptoms of anxiety, and a 40% improvement in knowing what resources are available in the community.

"This was just a small study to show the effectiveness of our social workers," Adams says.

The WellPoint social work case managers are master's-prepared licensed social workers who are fluent in English and Spanish and understand the Latino culture. One of the social workers is a naturalized U.S. citizen who was born in Mexico. The lead social worker has a doctorate in social work.

The social work case managers participate in daily virtual case rounds during which the interdisciplinary team reviews the members who are in the hospital and those with complex case management needs and collaborates on what services the members need. The medical director and the case management team also participate in the telephonic rounds.

In addition, the social workers alternate being "social worker of the day" to handle any urgent issues that arise. If there's a crisis situation, the social worker of the day contacts the client immediately.

"The social worker of the day typically handles one crisis situation every month or so when there are members who are threatening suicide or are decompensating from a behavioral health standpoint and need an immediate intervention," Adams says.

Routine referrals come to the social workers directly from the case management and medical management staff and through the daily multidisciplinary case rounds.

The social work case managers provide telephonic interventions and are regionally based so

they know the resources that are available in the community.

When they are referred to the social work program, Medicaid members are assigned to a specific social worker in their region. The social worker makes an outreach call, performs an assessment, and evaluates the member's psychosocial needs.

If it's a referral from an RN case manager, many of the social issues already have been identified, and the social worker begins to work on them, Adams says.

The social worker uses the Short Form 12 (SF-12) quality-of-life assessment to get a baseline reading of the members' perception of their medical and psychosocial conditions as well as anxiety and depression scales, a substance abuse scale, and a scale that measures the client's skills in accessing community resources.

The social worker case manager collaborates with the RN case manager to address the member's medical and psychosocial needs, Adams says.

Interventions could be as simple as assisting the client in getting connected with assistance with utilities, a housing assistance program, or a food bank or they may be as complex as dealing with significant behavioral health issues, she says.

"We try to take care of their psychosocial needs as soon as possible so the client can concentrate on his or her medical needs. Because of the challenges this population faces, one of the last things they are worried about is their treatment plan. If they don't have a place to stay, they're not going to worry about taking their medication correctly or checking their blood sugar. It's very important to address the other barriers first," she says.

Transportation is a big issue with the Medicaid population who often miss appointments with their doctors because they have no way to get there.

In rural areas, there often is no public transportation and few social services, Adams points out. That's when the social workers have to use their ingenuity and partner with community-based resources to get the clients the services they need.

"One of our areas has a large homeless population. Getting clients linked from the hospital to a homeless shelter or another type of alternative housing is a big problem," she says.

The social worker-RN case manager team in southern California collaborated to develop a plan of care for a homeless man who had diabetes and significant mental health issues, Adams recalls.

"The social worker was able to get him a room at a center that specializes in homeless people with behavioral health issues and got him linked to mental health services. When that part was completed, the case manager linked him with a primary care provider so he could get better management for his diabetes and avoid being rehospitalized," she says.

When clients are in the hospital, the RN case managers and social worker case managers make outreach calls to them if they are well enough to talk on the telephone and collaborate with the hospital discharge planners to ensure that the members have a safe discharge to home.

The case managers make sure that the hospitalized Medicaid members have follow-up physician appointments, and the social workers make sure they have transportation and other post-acute services.

"We want to make sure clients don't come back to the hospital because they have a problem getting their medication or their durable medical equipment. We help them access assistance programs and make sure they have what they need to follow their treatment plan at home," Adams says.

As they work with their clients, the social workers try to schedule telephone calls at a time when the clients will be available and able to talk.

"If it's not a good time for the client to talk, a telephone call doesn't accomplish much," Adams says.

One challenge with Medicaid clients is to improve their engagement, Adams says.

On average, the engagement rate with clients who have identified needs for social work is about 50%. The team is working to develop better ways to reach out to the Medicaid members, she adds.

If social workers or RN case managers cannot reach members or have trouble engaging them in an intervention, they can call on WellPoint out-

reach program community resource coordinators, who are bilingual non-clinical staff who live in the communities they serve.

"If we can't reach a client because he or she has changed locations or no longer has a telephone, we give the community resource coordinator specific information about the member's last known address and they go to the home and talk to the members," she says.

The community resource coordinator explains the program and tells them why the social worker or RN case manager needs to reach them, gives them the social worker's phone number and asks them to call.

Since they live in the community and meet with the clients face-to-face, the community resource coordinators often have success in engaging the members who may not understand the program or who are reluctant to talk to someone they don't know.

"There's a lot of distrust among this client population. If they don't know who's calling, they might not answer. Sometimes they mistake the health plan social worker for someone from a county agency or child protective services. Often they are fearful that they will lose their Medicaid benefits and they are anxious when they receive a call from a case manager or social worker. The community resource coordinators develop a rapport with the clients and help us overcome this obstacle to providing care," she adds. ■

Get rid of 'accidents waiting to happen'

Some problems hide in plain sight

Do you consider work areas as part of your "office?" If you do, you will almost certainly spot some unidentified Occupational Safety and Health Administration (OSHA) violations.

Occupational health nurse **Laurie Heagy**, RN, president of the Berks County Pennsylvania Association of Occupational Health Nurses, recalls that a subtle, but easily visible violation was spotted during one of her walk-throughs.

"The autoclave instrument solution is in a marked container. But when you pour it in the tray to disinfect, we did not have a label on the steel tray. So the solution was not identified and 'hiding in plain view,'" says Heagy.

There is no question that walking the floor can help you identify hazards that exist out in the workplace. However, **Craig Catton**, an environment, health & safety coordinator for Peoria, IL-based Caterpillar's Integrated Manufacturing Operations Division, says, it's even better to find them before they present a risk to employees.

This can be done by incorporating risk assessments into the planning phase of a new process. "When we buy a new machine, redesign a workstation, introduce a new chemical, or build a new product, there is an opportunity to eliminate the hazards before they are ever introduced into the work area," he says.

Make workers your allies

No matter how many walk-throughs you do, there is no substitute for the eyes and ears of employees. The challenge, though, is getting them to report what they see and hear.

"In some cases, things are obvious, like a missing guard. But in other cases, things are more subtle," says **Thomas Slavin**, safety and health director at Navistar International, a Warrenville, IL-based manufacturer of trucks and diesel engines. "Too often, though, nobody says anything about it."

An employee may know his actions are dangerous or non-complaint, but feels he must take the risk in order to get the job done.

"A lot of times, something's not right but nobody has ever said anything. Everybody assumes that's the way it's supposed to be," Slavin says. "But when somebody does ask the question, all of a sudden lights go off."

If an employee is doing a lot of work with their arms above their shoulders, for instance, it may be that a work platform needs to be adjusted. "It's not a case of being an OSHA compliance expert. Just asking a few questions gets people thinking," he says.

Use these approaches to obtain employee input:

• Don't pass up a chance to connect with employees.

While out on the shop floor, Catton always makes a point of speaking to employees and the management team.

"Employees who are encouraged to communicate safety and health issues, and who feel their management will address their issues, will be more likely to report issues and potential hazards," Catton says. "If employees are engaged, you will likely find

fewer health and safety hazards on the shop floor."

• Dedicate a specific time to identify hazards.

Some obvious hazards can easily be corrected by any employee, such as trip hazards from housekeeping issues or damaged tools. However, workers may do nothing to correct these accidents waiting to happen.

"Employees may continue to work with identified hazards, if they think taking time to correct the hazard will slow them down," says Catton.

For this reason, Catton recommends setting a designated time to identify hazards, such as the start of the shift or down time during the shift. "This allows workers time to focus solely on identifying and correcting potential safety issues in their areas," he says.

• Always do something when a problem is reported.

The goal is to encourage workers to continue to convey concerns. "People need to see that by bringing these things up, improvements are made in the workplace and things get done," says Slavin.

Navistar views OSHA compliance only as a "baseline," he notes. "Injury prevention, by doing a good investigation and talking to employees about what they think is unsafe, is really our focus. If you work from an injury prevention standpoint, it should take care of most of the OSHA standards," Slavin says.

• If an issue is identified and corrected, use it as an educational tool.

"The identified issue can be communicated at daily start up meetings to encourage other employees to look for the same issue in their areas," says Catton. "It is also a way to recognize the employees who helped identify and correct the issue."

[For more information on encouraging workers to report safety issues, contact:

Thomas Slavin, Safety and Health Director, Navistar International, Warrenville, IL. Phone: (312) 836-3929. E-mail: tom.slavin@navistar.com.] ■

Don't simply treat, discover root cause

'The avenue is there for investigation'

When an employee comes to you and tells you his shoulder is bothering him, you can do one of two things. You can either treat the problem and send him on his way, or you can dig deeper.

Thomas Slavin, safety and health director at Navistar International, a Warrenville, IL-based manufacturer of trucks and diesel engines, recommends the latter approach. He notes that the Japanese term "genchi genbutsu" is used in the Lean Manufacturing process, which translates as "go see the problem."

"The most effective occupational health professionals that I've worked with are the ones who actually go to the worksite to see what the person is doing, when someone comes in with a problem," he says.

By doing so, you may learn the real cause of the employee's pain or symptom. "A lot of things can be discovered when you see what their actions are. The symptom they come in with is really just a clue. And it's an important clue, that maybe no one else is aware of," says Slavin.

Take what a "root cause attitude," he advises. "People come in with a problem, but there are reasons for that problem," he says.

One investigative technique is the "Five Why," which means asking "Why?" repeatedly to get at the underlying cause of a problem. If an employee comes in with a foreign body in his eye, the reason is because he wasn't wearing safety glasses.

"A lot of people will stop there, and just say, 'You are not following the rules.' But you have to keep asking why," says Slavin. "When you start going deeper and asking additional questions, you uncover problems that can be corrected. There are a lot of benefits when you do correct them."

It may be that the glasses don't fit, fog up, that the person can't do a quality job with the glasses, or the lighting is poor.

Often, too, an employee has symptoms before an injury becomes severe. "When someone is having some pain, that is the first early indication that you need to look into that deeper," says Slavin.

Great opportunity

"The employee in your office for shoulder pain offers you a great opportunity to connect with the employee, as well as his or her department," says **Carol S. Harris**, RN, BSN, COHN-S/CM, an occupational health nurse at Replacements, a Greensboro, NC-based supplier of old and new china, crystal, silver, and collectibles with 550 employees.

By asking routine questions about the shoulder pain, you might discover a personal health issue

that makes the employee more subject to occupational injury than another employee doing the same job.

"This is a great way to connect with that employee during the health investigation, evaluation and perhaps medical intervention to improve that individual's health," she says. "In doing so, the potential is there for he or she to become a more productive employee."

There may be a problem at home that is negatively impacting the employee's health. "Once again, this shoulder evaluation may afford the employee time to address emotional problems," she says.

Simple questions during the exam about work processes can open the door for questions about morale or other issues that are creating a problem.

"This may not be the case, but the avenue is there for investigation," says Harris. "Saying, 'Let's go look at your job process together' speaks volumes to that employee. You show concern for them, and validate their importance."

When you go out into the field, the employee's co-workers then see your concern for their safety. "Spend time in the department to watch the employee do the job that is in question," she recommends.

As a result of these observations, you're in a better position to offer suggestions for work practices to decrease potential injuries in the future. "Demonstrate sincere concern for the employee," Harris says. "Then provide support for the management team by demonstrating concern for department safety, as well as production."

[For more information on learning more about an employee's injury, contact:

Carol S. Harris, RN, BSN, COHN-S/CM, Replacements, Greensboro, NC. Phone: (336) 697-3000, ext 2044. E-mail: carol.harris@replacements.com.] ■

It's not enough to know PPE isn't worn: Learn why

ID reasons for non-compliance

Is personal protective equipment (PPE) uncomfortable, too hot, poor-fitting or unattractive looking? The reality, very often, is that employees won't wear it.

Despite the risk of injury, employees don't always wear appropriate safety equipment, according to 98% of safety professionals surveyed by Dallas, TX-based Kimberly-Clark Professional—and 30% report this having happened on numerous occasions.

Increasingly high noncompliance with PPE protocols is a serious threat to worker health and safety, according to **Gina Tsiropoulos**, Kimberly-Clark's manufacturing segment marketing manager. "Because non-compliance remains an issue, we will continue to see work-related injury as a result," Tsiropoulos says.

Eye protection was cited as the "most challenging" PPE category by 42% of respondents. Nearly three out of five workers who experienced eye injuries were found not to be wearing eye protection at the time of the accident, or were wearing the wrong type of eye protection for the job, according to the Bureau of Labor Statistics.

"Clearly, we have a circumstance where workers are either not wearing safety glasses altogether, or are wearing the wrong kind or poorly-fitted eye protection," says **Deanna L. Thornton**, safety business leader for North America at Kimberly-Clark.

While the goal is always to prevent the injury, if an incident does occur it can serve as a "wake up call" to workers, Tsiropoulos says.

Test results demonstrating changes in hearing can reinforce loss related to misuse of, or failure to use, hearing protection. "Always ask questions such as 'Could gloves have prevented this hand injury?' or 'Could a bump cap or hard hat have prevented the laceration on the scalp from an overhead pipe?'" says Thornton.

Listen up

Hearing protection was the second most challenging area with PPE, the survey found.

"I think most occupational safety and health professionals think that more protection is better," says **Laurie Heagy**, RN, COHN-S, president of the Berks County Pennsylvania Association of Occupational Health Nurses. "In the case of hearing, I'm not sure that is the correct approach."

Heagy says that she is looking into using hearing protection devices that do not attenuate quite so much noise. She worries that the higher attenuating devices are decreasing compliance, because they block so much noise that the employee cannot hear normal speech.

"We have seen people modify the plugs to make it look like they are in, but they cut them

in half or use other methods so they can hear. This defeats the purpose of wearing them," says Heagy. "In an area that is only a few decibles above the OSHA [Occupational Safety and Health Administration] limit, you don't need a plug with a Noise Reduction Rating of 28 or 30. It is really overkill."

Heagy says that manufacturers should provide lower attenuating options, so that employees can be protected without isolating them from communication with their coworkers and supervisor.

"I had to tour two plants recently, and I got a really good fit on the hearing protection devices that they gave us," says Heagy. "I was frustrated because I barely heard anything that anyone was saying during the tours. It made me see what the employees go through."

Hearing protection devices should be selected with a goal of reducing the environmental noise to safe levels as directed by OSHA, and not to eliminate all sound entirely, Thornton says. "This type of 'overprotection' is impractical as well as dangerous," she adds. "Employees must be able to hear sounds to perform their jobs safely and effectively."

For more information on improving compliance with personal protective equipment, contact:

Laurie Heagy, RN, COHN-S, President, Berks County Pennsylvania Association of Occupational Health Nurses. E-mail: lheagy@hotmail.com.

Susan A. Randolph, MSN, RN, COHN-S, FAAOHN, Clinical Assistant Professor, Occupational Health Nursing Program, University of North Carolina at Chapel Hill. Phone: (919) 966-0979. Fax: (919) 966-8999. E-mail: susan.randolph@unc.edu.] ■

The needlestick that changed her life

ANA pres recalls injury that led to HIV, HCV

Karen Daley, PhD, MPH, RN, FAAN, remembers the stick as if it happened in slow-motion, the details still clear to her 12 years later.

She had helped a co-worker draw blood from a patient in the emergency department. She turned to reach behind her for the sharps container. Mounted high on the wall, it was overfilled, but she couldn't see it well because it was above eye level. As she released the device, she felt a deep puncture through the index finger of her gloved hand. Someone else's needle had stuck her. Source patient unknown.

The odds, seemingly, were in Daley's favor. What's to say that source patient had a blood-borne disease? Even if he or she did, the rate of conversion for hepatitis C is estimated at just 5 in 1,000 (.5%) and at 3 in 1,000 (.3%) for HIV. At first, she was inclined to just rinse off her finger and ignore the injury.

"I wanted to just forget about it and go home," she recalls.

She reported to urgent care for evaluation because her co-worker urged her to do so. She declined the post-exposure prophylaxis for HIV because she was aware of the toxic nature of the side effects of the anti-viral medicines. Even when she began to have symptoms — weight loss, nausea, fatigue, abdominal pain — she didn't connect them to the needlestick. After all, she was suffering from emotional stress because of the recent death of her brother.

But Karen Daley, now president of the American Nurses Association in Silver Spring, MD, was doubly unlucky. She became infected with both hepatitis C and HIV from that needlestick. It was a moment that altered her life — and made her a vocal advocate for sharps safety.

"When my needlestick occurred, few employers were making safety devices available to workers. Only 15% of employers provided any type of sharps safety device," says Daley.

Laws spurred sharps safety

California became the first state to mandate safety-engineered sharps devices in 1998. In 1999, when the National Institute for Occupational Safety and Health issued an alert to hospitals regarding sharps injuries, an estimated 600,000 to 800,000 health care workers were being stuck every year.

Yet hospitals were still arguing that new safety devices were too expensive. "You hope employers and workers will do the right thing for the right reason. That's not always the case and it wasn't the case here," says Daley. Daley traveled the country, speaking out about her needlestick and its dire consequences — and the simple device that could have saved her health. She testified before state legislatures and Congress, and helped promote ANA's campaign,

"Safe Needles Save Lives."

Other states began requiring the use of safety devices, but the passage of the Needlestick Safety and Prevention Act in 2000 propelled the issue forward with a mandate that employers purchase the safety devices.

Now, when Daley has her blood drawn for regular lab work, she is gratified to see the nurse or phlebotomist using safety equipment.

"Nurses who practice now as recent grads don't know there was a time when we didn't have access to these devices. It's just the norm," she says.

Maintaining enforcement is critical, she says.

"I want every nurse in the country and every employer to realize what their obligation is under this law, and I want to see them comply with that," she says.

Moving forward after stick

The day that Daley learned she was both HCV and HIV positive was her last day of work as a practicing nurse. Emotionally, the news was devastating.

"I was dealing with a life-threatening illness," she says.

Physically, she was in bad shape. She developed acute hepatitis and she had a high HIV viral load. She went on a year-long therapy for hepatitis C and was able to clear the infection. She also took anti-viral drugs for HIV, which was a struggle.

"I had a difficult couple of years trying to get on a regimen that was tolerable for me," she says. "At one point, I had to stop the entire treatment. I couldn't eat. The fatigue was so excessive."

She tried about four different drug protocols until finding one she could maintain. She has been on the same drug regimen for seven years. As ANA president, Daley is committed to working on some of the remaining gaps in sharps safety — the lack of access to safety devices in the OR, the failure of some employers to include frontline nurses in device selection (as required), the lack of availability of safety devices in some categories. Most of all, Daley wants to promote a culture of safety that compels workers to report their injuries and that encourages timely post-exposure prophylaxis.

"Where there are opportunities for us to make the workplace a healthier, better place, we have an ethical obligation to do so," she says. "We've still got some work to do." ■

COMING IN FUTURE MONTHS

- Career opportunities for case management
- Metabolic syndrome case management
- How accountable care organizations work
- Hospital-community partnerships pay dividends

CNE QUESTIONS

21. According to Nancy Kehiayan, MS, RN, APRN-BC, participants in the nurse-family partnership program found positive changes often in a short period of time.
A. True
B. False

22. Jane McKinley, RN, BSN, says she often uses reflective consultation in working with clients.
A. True
B. False

23. Which is recommended regarding eliminating workplace safety hazards?
A. Don't set a designated time to identify hazards, such as the start of the shift.
B. Avoid discussing hazards during the down time of the shift.
C. After an issue is identified and corrected, avoid discussing this specific issue at staff meetings.
D. While you are doing walk-throughs, make a point of speaking to employees and the management team.

24. Which is recommended to improve compliance with personal protective equipment (PPE?)
A. Don't require employees to identify lapses in PPE compliance involving other workers.
B. Offer only one type of PPE, instead of giving employees more than one choice.
C. Require employees to identify any lapse in PPE compliance.
D. Don't give employees the opportunity to test out different PPE products.

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

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

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