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Post-acute transition program cuts LOS in SNFs for participants

Case managers visit facilities, collaborate with staff, patients

UnitedHealthcare's post-acute transition program has reduced the average length of stay in skilled nursing facilities by three to five days, depending on the market, for members in the program.

"Inpatient stays are some of the most stressful and unsettling health care events members experience," says **Rhonda I. Randall**, MD, chief medical officer for UnitedHealthcare Medicare & Retirement.

"Our care managers work collaboratively with facilities, families, and caregivers to ensure members receive the right care, in the right place, and at the right time," she adds.

The program, which began in 2005, provides face-to-face case management for Medicare Advantage members who are discharged from the acute care hospital to a skilled nursing facility.

"Our program focuses on the member and making sure the members get appropriate services at the appropriate level of care. What has resulted has been a reduction in the length of stay. We want to be good stewards of a member's medical dollars and remove the barriers so they don't experience unnecessary delays in services," says **Michelle McPhillips**, RN, CCM, BA, program director for the post-acute transition program.

Planning for the program started in late 2004 as a way to ensure that transitions to post-acute facilities go smoothly and that the members get the services they need in a timely manner so they don't stay longer than necessary, McPhillips says.

The program began with a pilot project in Ohio in mid-2005. During the pilot, two nurse case managers, hired in separate markets, visited participating skilled nursing facilities. They evaluated the members early in their post-acute stay, met with them every week, talked with family members, and monitored the members' progress.

"Often the people in our program are the frail and elderly patients with comorbidities who are at risk for frequent hospitalizations and require a lot of care. Many of these members are admitted to the hospital with

pneumonia, heart failure, or respiratory conditions that put them at risk for frequent hospitalizations. We wanted to make sure that the transitions were smooth," McPhillips says.

Following the success of the pilot project, the health plan has instituted the program in geographic areas where there is a large population of members who could benefit from the program.

Many of the patients have multiple comorbidities such as heart failure, diabetes, a respiratory condition such as chronic obstructive pulmonary disease, or pneumonia. Many members have dementia and cognitive issues. Some have had joint replacement surgery or suffered a stroke.

The members no longer meet inpatient criteria but have had a decline in function during their hospital stay that makes a discharge to home impossible.

"They have to learn how to get back to walking or transferring, or they may need continued medical treatment such as wound care or IV antibiotics. A lot of their needs are therapy-related," McPhillips says.

The nurses work in facilities where significant numbers of members are admitted. The nurses are assigned to facilities within a geographic area. They make rounds in facilities at least once a week. When there are a lot of members in the facility, the nurse may round twice a week.

"It's a hands-on program. The nurses visit with the member every week, talk with the family and caregivers and involve them in the plan of care, and work with the interdisciplinary team at the facility," she says.

By being in the facility regularly, the case managers are viewed as part of the interdisciplinary team, McPhillips says.

"It helps us move the member along because everybody is on the same page," she says.

When a member is newly admitted, the case manager completes a comprehensive assessment and begins to develop goals for discharge.

"We invite them from day one to participate in setting their goals. Most people want to go home, but, unfortunately, that may not be realistic," she says.

Most of the members in the program are covered by United's Medicare Advantage plan. Some have a chronic illness plan.

The case manager determines the member's baseline functionality before hospitalization, what caregiver support will be available after discharge, and other services the member already has.

"When we meet with the member, we get permission to make a follow-up phone call to the family and caregiver. We review the medical record and speak with the therapist and nurse on the unit to find out how well the patient is doing medically and from a therapy standpoint," she says.

The case managers see the members a minimum of once a week.

They spend a lot of time building a rapport with members and their family and including them in developing the discharge plan.

"We want to make sure that people are medi-

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cally and functionally stable to go home and that the discharge plan is as safe as possible. We give the member and family the information they need to make decisions about the discharge destination," she says.

For example, a member may want to go home, but that may not be a safe discharge option.

"This is always a difficult situation. That's why the onsite program is so beneficial to the member and to us. It's better to have difficult discussions face-to-face than over the phone. The case managers get to know the members and their families by being there consistently throughout the entire stay, and this makes it easier to talk about discharge options," she says.

They collaborate with the treatment team at the facility to develop the member's plan of care.

"We want to make sure that the services the member needs are provided in the skilled level of care, that they are receiving the appropriate modalities, and that they have the equipment they need. That's why it's so important to partner with the facility. If the case manager has questions about member needs or wants to talk to the physician, they are comfortable in asking because they have a relationship with the staff," McPhillips says.

As the day of discharge approaches, the United case managers focus on preparing members for discharge, making sure they know to get their prescriptions filled, when the follow-up with their physician is, and who to call if they don't hear from home health services.

They make sure their post-discharge needs are being met so the patients don't stay longer than necessary in the facility until home care visits are set up or durable medical equipment is delivered.

If the case manager has concerns about the member's living situation after discharge, he or she asks the skilled facility to send someone to conduct a home assessment.

The duties of the case managers focus more on making sure that the members get what they need in the skilled nursing facility and that they have what they need after discharge, rather than spending a lot of time educating them about managing their conditions after discharge.

"These patients have so many issues going on while they are in the skilled nursing facility that they aren't in the state of mind to benefit from a lot of education. We do a lot of coaching with the caregivers, and the therapists work with them to make sure they understand the capabilities of the member after they return home," she says.

The nurses often identify members who would be eligible for United's disease management or telephonic case management programs.

"Our program focuses on members while they are in the skilled facilities. When the members are discharged, the case managers collaborate on handing them off to nurses in other programs that may benefit them," she says.

The case managers give business cards to the members so they and their families call with questions or concerns. It's not unusual for a case manager to receive a phone call six months after the case is close from a member saying, "You really helped me when I needed it," McPhillips says.

The case managers typically have a caseload of 20 to 24 members at a time.

"The team is all remote, which brings challenges," she says. The nurses have home offices and start the day answering e-mails, then round in the field between 10 a.m. and 3 p.m.

At the end of the day, the nurses go back to their home office, catch up on paperwork, and communicate with family members.

The nurses are in the field four days a week and spend one day catching up on their phone calls and documentation.

The program employs nurses with a case management background who are experienced in more than one level of care so they understand the whole continuum of care. "Many on the team are certified case managers or are pursuing certification," she says.

Some of the nurses have hospital backgrounds. Others have experience in a skilled nursing or rehabilitation setting or a hospice background.

"The skill set for case managers is very important for an onsite position. The biggest part of the job is relationship-building. The nurses are on site at multiple facilities and must be able to communicate. They must collaborate with members and families in care planning and partner with the facility staff and physicians. Collaboration and communication doesn't come naturally to everyone," McPhillips says.

The program has a low turnover rate, McPhillips says.

"Most of our staff have been with the program from the day we opened up in their state. They're here because of the members. They get so much from seeing the members being able to improve and go home and from seeing the dedication and

development of the caregivers. My mantra is, 'It's all about the members.' Everyone has the member's goals in mind," she says. ■

Physicians, health plan, hospital team up

At least a 30% drop in rehospitalizations

When a health plan, a physician network, and a hospital teamed up to reverse the trend of Medicare hospital readmissions within 30 days of discharge, readmissions dropped by 30% or more over an eight-month period when compared to the readmission rate in the same hospital the previous year.

According to data compiled through September 2010, patients in the program had a 9.25% readmission rate compared to 16.5% for a similar group in 2009.

"Hospital readmissions are a costly problem for everyone. The triple goals of this program are to improve quality of care and the patient experience while reducing readmissions Each prevented readmission will keep patients healthier and could save almost $10,000 per patient," says **Barry Baines**, MD, associate medical director of U-Care, an independent, nonprofit health plan.

The project is a joint effort of U-Care, based in Minneapolis; Fairview Physicians Associates (FPA), a large network of primary care and specialty providers; and Fairview Southdale Hospital, both located in Edina, MN.

The initiative involves collaboration between the hospitalist, the discharge planner, and the pharmacist at the hospital and the case manager and the primary care provider, Baines says.

"All of these professionals work together to ensure that the patient is safely discharged back home. We ensure a safe transition by making sure the patient knows what medication to take and when to take it, that they have the equipment and post-acute care they need, and that they have a timely follow-up visit."

U-Care provides an incentive to the primary care physicians to see patients within five days after discharge and provides funds to the hospital for a pharmacist to evaluate patients in the program.

The pilot project, which began Feb. 1, 2010, targets patients covered by U-Care for Seniors Medicare Advantage plan who are hospitalized and who have diabetes, chronic obstructive pulmonary disease, or heart disease, or a combination of the three, Baines says.

"Because they are seniors, many of our members admitted to the hospital have one or more of these conditions," Baines says.

When a patient is admitted to Fairview Southdale Hospital, the case manager at Fairview Physicians Associates is notified within 24 hours, according to **Becky Schmidt**, RN-BC, manager of care delivery and clinical operations for the physician organization.

The hospital and FPA case managers use software that allows direct communication between the case manager and the staff at the hospital.

"We get a notification every morning listing all of our patients who have been hospitalized. When a U-Care for Seniors patient is identified through the admission report, we activate our tool so that the social workers, nursing staff, hospitalists, health information management system, and pharmacy staff are aware that the patient is in the pilot," Schmidt says.

Because the physician network provides case management for all of its patients, the FPA case managers have information about the patients' conditions and the care they have been receiving as well as any services they in place or have had in the past, Schmidt says. For instance, some congestive heart failure patients are on a self-management program. Others may be receiving telemanagement. The case managers also have a record of any post-acute services, such as home health, that the patient has used in the past.

"The case manager informs the hospital social worker about what has been going on with the patient before hospitalization. That way, they don't have to re-create the wheel," Schmidt says.

The FPA case managers visit the patient in the hospital to check on his or her condition and to help coordinate any care the patient may need after discharge.

They follow up with the hospital social worker by phone or by electronic communication.

"This communication puts everyone on the same page so there are no surprises at discharge," Baines says.

Before discharge, the patient is visited by a pharmacist who completes medication therapy management and discusses the medication regimen with the patient.

"Pharmaceutical reconciliation or issues with medication are the reason for between a third and a half of readmissions. In some cases, the patient is taking medication he shouldn't take. In other instances, he or she is taking a generic prescribed before admission and an identical drug prescribed in the hospital or simply hasn't gotten the prescriptions filled," Baines says.

The pharmacist's role goes beyond typical medication reconciliation, Schmidt says.

"The pharmacist is not simply handing the patient a list of what new medications he's taking and what he came in with. He's looking at the big picture. A congestive heart patient may be managing multiple medications very well, but if one is changed, it could be confusing. We take a proactive approach to eliminating any medication problems that could occur after discharge," she says.

The Fairview Physician Associates case manager works with the hospital discharge planner to make sure the patient has everything set up, such as durable medical equipment and oxygen, and making sure home health is in place if that's appropriate, Baines says.

"One of the more important aspects of the program is to ensure that the patient has a follow-up visit with a primary care provider within five days," he says.

The hospitalists also are alerted when a patient is in the pilot project. Their responsibility is to emphasize that the patient needs a follow-up appointment within five days after discharge and to provide a discharge summary to the primary care physician within 24 hours of discharge, Schmidt says.

"We know that the primary care physician is at the heart of the care plan. Our communications tool alerts the hospitalists when a patient in the pilot is in the hospital. They know to facilitate a follow-up appointment," Schmidt says.

The primary care clinics have accepted the responsibility of seeing patients within five business days by being flexible and getting patients in, she adds. When a patient has a primary care visit, the case manager receives a visit summary from the clinic.

The case managers at FPA call the patients within 24 to 48 hours of discharge, then again at 14 days and 28 days after discharge.

"These phone calls are instrumental in identifying what problems are occurring before the patient winds up back in the hospital," Baines says.

The case managers reinforce the education the patients received in the hospital and find out if they need anything else. "If they haven't made a follow-up appointment, we offer to help them call the clinic," Schmidt says.

"The case managers work to engage the patients in their own care. They don't just tell patients to do something. They provide an explanation and education. We are looking at the big picture and partnering with the patients to make the discharge safe and successful," she says.

Fairview Physician Associates has always had case management as part of its contract with U-Care for Seniors, Baines says.

"All our care systems offer complex medical case management. For this project, FPA reallocated some of their case managers to the program and are taking more of a broad focus using predictive modeling to assess the most at risk patients," he says. ■

Medical home focuses on engaging patients

Approach helps maximize visits with physician

A week or 10 days before patients have an appointment with a physician at Primary Care of Southbury in Danbury, CT, a nurse or medical assistant calls them to determine if they've been following through on their treatment plan and have everything in place for the appointment.

"The goal is not to wait until a patient comes to an appointment and has forgotten to get lab work done or record his blood pressure readings. We are being proactive to make sure we have everything needed to make the most out of the visit," says **Robert Carr**, MD, a physician at Primary Care of Southbury.

The initiative is just part of the Danbury Office of Physician Services' efforts to advance quality health care by creating patient-centered medical homes. The organization is a large multispecialty physician group that works closely with Danbury Hospital.

Primary Care of Southbury and Brookfield Family Medicine are the first two practices in the organization that have been certified by the National Committee for Quality Assurance (NCQA) as patient-centered medical homes.

"The benefit of being a patient-centered medical home is that we can coordinate care

for patients across the whole health system. We don't wait for the patients to make an appointment for an episode of care. The goal is to maintain an ongoing relationship with patients and proactively address their chronic health care needs as well as treating any acute complaints they may have," Carr says.

The emphasis in a patient-centered medical home is on strengthening the doctor-patient relationship and creating a long-term relationship between the patient and the treatment team, Carr says.

"It's like the old-fashioned family doctor of decades ago; only now the physician is working with a multidisciplinary team that may include nurses, dieticians, therapist, pharmacists, and others. All of the patient's health care needs are coordinated through the medical home, either on site, or along the continuum of care. In the old model, it was easier for things to fall through the cracks. Now we work with the hospital case managers and visiting nurses to make sure patients get everything they need," Carr says.

Under the old model of care, the physician would give the patient a treatment plan and ask him or her to come back in two or three months for a follow-up visit, Carr says.

"By that time, the patient may have forgotten the plan or not maintained it," he adds.

Under the new system, a nurse contacts patients between visits and makes sure they understand the plan and are following it and that they have the necessary resources to manage their condition.

The contact between visits helps patients become engaged in their care plan rather than thinking it of as something the doctor is doing, Carr points out.

"This is a more proactive and comprehensive approach that continues over time so patients don't feel like they get attention only every three months," he says.

When patients are diagnosed with a chronic disease, they need more attention than the treatment team can give them during an episodic visit, Carr says.

"We do a lot of population management. We know who the patients are who have diabetes, congestive heart failure, or other chronic conditions. We keep in touch with them proactively so we make sure they get the preventive care and patient education they need in addition to acute care. Not everybody needs contact between visits. On the other hand, some patients have so many comorbidities that they may need several contacts," he says.

The model focuses on patient engagement so patients feel like they're an important part of the healing process, Carr says.

"It's designed to be more personalized and to give patients help in being successful. By coordinating all aspects of care throughout the continuum, we help patients navigate our complex health care delivery system so nothing falls through the cracks," he says.

For instance, the hospitalists in the medical group alert the individual practices when their patients are in the hospital.

The electronic system also connects specialists and the primary care physicians, making coordination of care easier, Carr says.

"All offices have online access to the electronic record, the physician notes, history and physicals, and can follow the patient while they are in the hospital. The primary care physician automatically receives a copy of the discharge summary from the discharging physician," he says.

The hospitalists and discharge planners at the hospital have access to the appointment calendars for the primary care physicians and can schedule follow-up appointments before the patient leaves the hospital.

"They can go into the schedule and make a follow-up appointment for a patient without having to talk to the office staff. In the old system, the hospitalist would tell the patient to follow up with the primary care physician, and they might not be able to get in for six weeks," he says.

The primary care offices have allowed double-booking if it's a hospital follow-up or they have appointments available for people coming out of the hospital, he adds.

When patients are discharged from the hospital, a nurse from the doctor's office follows up with them to make sure they have everything they need to recover at home and that they have a follow-up visit with a physician.

"The time most people experience problems that send them back to the hospital is between the time they are discharged from the hospital and the time they see their doctor for a follow-up appointment. That's why we have the nurse contact them in the interim to make sure they understand their discharge instructions, that they have medication and equipment they need, and that they have transportation to the follow-up visit," he says.

Sometimes patients have appointments with their primary care physician and a specialist. In

these cases, the nurses help them sort out which visit is for which doctor.

Another benefit of the patient-centered medical home is that everybody in the physician office works at the highest level of their license, Carr says.

"The process of patient care begins at the front desk and continues with the medical assistants and nursing staff, freeing the doctor to focus on the patient's more complicated medical needs. Each profession is focusing on the things they do best and fully utilizing their skills and talents," he says.

For instance, people at the front desk may recognize things a patient may need for the visit. For instance, if the patient is going to need lab work, they make sure that it's done before the doctor sees the patient.

"A lot can happen before the doctor walks into the room. In the old model, the staff mainly focused on getting the patient in the room and ready to see the doctor. This model engages the whole staff to be more involved in patient care," he says. ■

Make changes for OSHA recordkeeping

Common pitfalls to compliance

There is no question about it: Occupational Safety and Health Administration (OSHA) violations for recordkeeping are increasing significantly, and companies are getting hit with heavy fines.

Regularly monitoring the OSHA 300 log to ensure its accuracy is one way to stay in compliance. "Make sure cases have been entered correctly," says **Patricia B. Strasser**, PhD, RN, COHN-S/CM, FAAOHN, principal of Partners in BusinessHealth Solutions in Toledo, OH. "Track cases and update the log as needed after the initial entry." Strasser recommends these other steps:

- If you are not responsible for entering the data on the OSHA 300 log, ensure that you're in regular communication with the person who is.
- Ensure there is good documentation regarding how and why decisions are made. "This is especially important where the decision is made to not put the case on the OSHA log," notes Strasser.
- Maintain all the required documentation in an easily accessible location.
- Perform proactive recordkeeping audits.

"Review all pertinent documents related to injuries and workers' compensation cases in the five calendar year OSHA window, to ensure accuracy of the OSHA logs," says Strasser. "Or if the number of cases is very large, audit a representative sample of the cases."

The usual suspects

Here are common violations of the Occupational Safety and Health Administration (OSHA)'s recordkeeping standards to watch for:

- Someone makes an incorrect decision that a particular case does not meet recording criteria.

"Many omissions or errors result from not fully understanding the rule," Strasser says. There may be confusion over the definitions of "first aid," the "geographic presumption" of work-relatedness, "significant aggravation," or what constitutes a "new case."

- Workers' compensation requirements are mistakenly equated with OSHA recording criteria.

Strasser says she has seen many instances where a case is not recorded because the case was "denied" and is not compensable under the state workers' compensation statute.

"It's erroneous to think that workers' compensation and OSHA requirements are the same," says Strasser. "OSHA stipulates that recording a case is not an indication of workers' compensation eligibility."

Depending on the state workers' compensation statute, a case may not be considered "work-related" under the statute. However, it may meet OSHA recording criteria, and vice versa.

- There is confusion over what qualifies as "first aid" versus "medical treatment," for recordability purposes.

Michelle L. McCarthy, RN, COHN, on-site medical case manager for Genex Services in Norcross, GA, says that examples of "First Aid" injuries are a wound that requires only a tetanus shot, a minor strain that only needs over-the-counter medications and no restrictions, or an X-ray for diagnostic purposes if the X-ray is negative and no medications, restrictions or splints are given.

Any injury requiring prescription strength medication or a splint with a "hard" stay in it (such as a cock-up wrist splint or Aircast ankle brace),

any type of fracture, or anything that restricts the employee's normal job functions and/or moves them from their work area, is recordable, says McCarthy.

• There is a misunderstanding regarding the definition of an OSHA-recordable "work restriction."

Employers may believe that an injury is not recordable as a work restriction if the injured employee can still perform any useful work. "However, the OSHA standard requires the injury to be recorded as a work restriction when the injured employee is restricted from doing any of the 'routine functions' of his job," says **Eric J. Conn**, a partner based in the Washington, DC office of McDermott Will & Emery. Conn's practice focuses on occupational safety and health law.

• Data are incomplete or out of date.

"The OSHA log requires a lot of data. It is easy to inadvertently omit an element, such as a job description," says **Thomas Slavin**, safety and health director at Navistar International, a Warrenville, IL-based manufacturer of trucks and diesel engines. "Keeping track of days away or restricted activity days can be a challenge that requires coordination and follow up."

• Treatment by a personal physician or outside clinic affects recordability.

Someone you treat may go to their own physician later and get a different course of treatment, such as a prescription or work restriction. This may make the case recordable. "It is not always clear what medications or procedures were used when dealing with outside clinics or emergency rooms," says Slavin. "It is critical to confirm whether or not such treatment would make a case recordable."

• Documentation is incomplete.

Many cases are complex, and there is often good rationale for making a decision about recordability. However, both the decision and the rationale behind it should be clearly documented.

"Even if OSHA would second guess the decision later, the documentation would show good faith," says Slavin. "Avoid any consideration of a willful violation, for making what they consider a wrong judgment call."

[For more information on preventing record-keeping violations, contact:

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Want workers to listen to you? Gain their trust

Get your message out

If employees don't trust you, they probably won't listen to your advice, agree to take a health risk assessment, or participate in your wellness programs.

Talei Akahoshi, director of occupational health at Piedmont Healthcare, says you must be proactive in reaching out to employees. She gives these recommendations to establish trust:

• **Make yourself visible.**

"Our employees like seeing faces they know. One-on-one events on site, with individual attention, increases participation rates," says Akahoshi.

• **Engage middle management.**

"If they are not supportive, those below will be less likely to participate," says Akahoshi. "They are my biggest supporters in reaching my employees. How do you do it? That is the million dollar question."

Akahoshi says you need to have several approaches to gain middle management support, as follows:

— First, they have to know that there is senior leadership support. "Get them to participate or endorse your programs," says Akahoshi.

— Be open and honest with your middle managers.

— Show managers the results of their actions. For example, report participation rates weekly, and show which entity or department are top performers.

— Make sure they have the right resources and tools. "They may not have all the informa-

tion to assist you, or may feel uncomfortable," says Akahoshi. "Address any of their concerns."

— Support them by making yourself available.

"Ask if you can attend one of their staff meetings," says Akahoshi.

— Perhaps most importantly, make sure they know why you need their support.

"Have a manager tell a story of how they made a difference," Akahoshi suggests.

• Be sure that everyone on your team is able to answer questions.

There must be a clear, consistent message communicated to employees. "If your occ health team is not on board or isn't selling it, who will?" asks Akahoshi.

Leave door open

For **Michelle L. McCarthy**, RN, COHN, onsite medical case manager for Genex Services in Norcross, GA, saying "my door is always open," is more than just an expression. "You actually need to leave the door open! Acknowledge associates as they walk by. This lets them know they aren't bothering you."

The only time McCarthy shuts her door is when an employee is already in her office with a concern. "Do not multi-task when talking to associates. Make eye contact, and repeat questions to ensure they know you are listening," she advises.

Follow up with that employee later in the week to see how he or she is doing, or to provide answers to questions. "If they have a question or problem and you don't know the answer, admit it," says McCarthy. "But let them know you will find it!"

Any time you're out in the building, make eye contact, speak to associates, and encourage them to drop by any time, advises McCarthy.

When walking through the buildings to speak with workers, McCarthy makes a point of asking questions about how they do their job. "I find that they are much more forthcoming with information," she adds.

[For more information on establishing trust with employees, contact:

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Not measuring worker productivity? Start now

Paradigm shift underway

New and better tools are needed to measure employee productivity, according to a new position paper.[1] The authors focused on the use of productivity measurement tools in meeting real-world business challenges.

They concluded that the best tool for measuring productivity depends on the purposes of measurement, and how the information will be used. Here are three categories of tools to measure productivity:

— "Descriptive measurement" looks at the effects of health on worker performance;

— "Comparative measurement" examines the impact of various health risks and conditions;

— "Evaluative measurement," focuses on changes in productivity over time, which is a critical consideration in judging the benefits of employee health programs.

According to the paper, worker health and productivity data must be formatted in a way that makes it usable by decision makers. "Dashboard" formats are one good approach, because the data is presented in a clear and concise manner. This allows leadership to get a clear picture of how health status affects worker performance.

Steve Schwartz, PhD, research director of HealthMedia in Ann Arbor, MI, and the paper's lead author, says that a paradigm shift is underway.

"There is a business imperative that is beginning to get traction with employers," says Schwartz. "Progressive and successful companies are now investing in the health and well-being of their workforce."

Doing this effectively impacts direct healthcare expenditures, but also the productivity and performance of employees. "This paper provides a justification for measuring productivity related to health status, in valid and actionable ways," says Schwartz.

Schwartz says that measuring productivity is in "a state of flux." This is because of increasing numbers of service sector jobs as opposed to manufacturing jobs, which means that traditional methodologies aren't always applicable.

"Piece work — actual count of products — or time and motion studies that worked well in a manufacturing environment do not lend themselves to the service sector," says Schwartz.

Self-report measures are emerging as the measurement method of choice. "While they have some challenges related to recall and other forms of report bias, they have the advantage of being more appropriate for most jobs that do not produce a concrete work output," says Schwartz.

They are also easy and economical to administer. "While some are skeptical of their validity, the development of valid and reliable self report measures of productivity is absolutely doable," says Schwartz.

REFERENCE

1. Schwartz SM, Riedel J. Productivity and health: best practices for better measures of productivity. *J Occup Environ Med*. 2010;52(9):865-871. ■

Wellness metrics point to HCW health risks

Employees learn to avoid chronic disease

When Washington County Health System (now known as Meritus Health) in Hagerstown, MD, first sought to measure the health status of its employees, the results were startling. Thirty-eight employees had undiagnosed diabetes or high blood pressure. More than 500 had glucose levels that placed them at high risk for developing diabetes. Other employees had high blood pressure, high cholesterol, or other risk factors.

Those metrics became the impetus for change. Employees received their own, confidential information on "modifiable risks" that showed how they could avoid the dire health consequences by making lifestyle changes. A comprehensive wellness program gave them support toward healthier habits.

Two years later, the hospital sees promising results. A survey showed that a significant number of employees have quit smoking, started taking medication for high blood pressure or other problems, lost weight, or started exercising. The estimated savings: At least $377,000 in decreased health care costs.

The hospital, which recently moved into a new facility and changed its name to Meritus Medical Center, hopes the metrics-based "Know Your Number" wellness program will help employees make further gains. "The true benefit is long-term, when you're not just treating disease, but you're preventing disease," says **Wendy Atkinson**, director of operations for THP TriState Health Partners, the health management company affiliated with Meritus Health. "By preventing these diseases and working in earlier points of intervention, we can actually save [health care] dollars."

Tying health assessments to identifiable risk of disease is the basis of BioSignia, a Durham, NC-based company that uses patented algorithms to create "Know Your Number," a calculation of an individual's risk of various diseases, including heart disease, stroke, high blood pressure, and stroke, within a five-year time frame. With the "Know Your Number" health risk assessment, each employee receives a summary that shows how she or he compares to their peers of the same age and gender.

The bar graphs also show how much of that risk could be modified; often, the modifiable risk is as high as 70% to 80%. Understanding the risk can prod people to make lifestyle changes they wouldn't otherwise have made, says **Mark Ruby**, BioSignia's senior vice president of corporate business development.

"You have to know you've got a problem before you start going down the pathway to solve it. I may know I've got excess weight. I may know I have high blood pressure. But this is the first time I've had an assessment that actually translates that into my actual risk to getting [heart] disease [or stroke]," says Ruby. "More than that, you're giving me a roadmap to change."

The employee's information remains confidential and is not shared with the employer. But the employer does receive reports that show aggregate numbers. Know Your Number predicts future new disease burden in the screened population — how many of their employees have high health risks, how many new cases of disease will occur, and what percentage of new cases are avoidable. "That's the ultimate solution to health care costs," says Ruby. "A paradigm shift is happening."

At Meritus Health, the Know Your Number employee aggregate report predicted there would be 70 new Type 2 diabetes cases among the employees in the next five years, 59 of them pre-

ventable. The primary contributor to the diabetes risk was excess weight.

Ruby notes that nationally, more and more employers are investing in wellness as a way to control the medical costs of employees. For hospitals, there is another imperative. It doesn't make sense if hospitals are "delivering the health care but not living it," says Atkinson. "It's important for health care workers to be role models."

Obtaining that detailed health risk assessment requires the collection of key markers. It includes the usual: weight and height to calculate body-mass index, smoking status, blood pressure. The metrics also include fasting glucose and cholesterol.

Meritus Health spurs participation with a premium differential. Employees who decline to take the health risk assessment are required to pay $30 per month in additional health care premiums.

At first, that ruffled a few feathers, but the health system succeeded in winning over employees with a comprehensive wellness program that includes fitness, nutrition, and wellness classes as well as one-on-one health coaching.

"You really can't make any changes if you don't know what you need to change," says Atkinson. "This tool helps you target [areas] where you can make some positive impact."

A wellness committee helped shape the types of programs offered by the health system. It includes some people who were recommended by managers as employees who would be likely users of the program, as well as some skeptics. "A wellness team or a wellness committee needs to be representative of your population," says Atkinson.

The committee conducted surveys to find out what types of wellness activities employees would want and what educational topics would interest them. Atkinson also joined the Wellness Council of America (www.welcoa.org) to gain access to wellness resources. (The Wellness Council offers sample employee surveys, wellness brochures, and guides to creating a program.)

The wellness committee drafted a plan with some basic goals to improve employee weight management and smoking cessation. With the support of senior leadership, the hospital has designed walking paths in its new facility and added healthy choices and nutritional information in the cafeteria.

Even the snacks at in-house meetings changed. "There is alignment that has to happen," says Atkinson. "If you have meetings and serve cookies, you're really working against yourself."

The risk assessment also includes a behavioral health component that can identify employees who suffer from high levels of stress or depression. Once they are identified, THP's behavioral health coach/case manager reaches out to offer help.

Some changes are easy to measure — pounds lost, smokers who quit. But the awareness of health and disease risks will show results over time, says Ruby. After all, rising medical costs are daunting for all employers, including hospitals. "The solution many times is in front of people's noses," he says. "If 70% to 80% of disease is avoidable, why aren't we avoiding it?" ■

COMING IN FUTURE MONTHS

- Helping seniors stay healthy at home
- House calls making a comeback
- How to engage Medicaid beneficiaries in managing care
- New employment opportunities for case managers

CNE QUESTIONS

5. What year did UnitedHealthcare's post-acute transition program begin?
A. 2002
B. 2003
C. 2004
D. 2005

6. According to **Barry Baines**, MD, each prevented readmission to the hospital could save almost $10,000 per patient.
A. True
B. False

7. Which is true regarding violations of the Occupational Safety and Health Administration (OSHA)'s recordkeeping standards?
A. It is not advisable to document the reasoning behind a decision not to put a case on the OSHA log.
B. Recording a case is an indication of workers' compensation eligibility.
C. If a case is not compensable under the state worker's compensation statute, this means that the case is not recordable.
D. Depending on the state workers' compensation statute, a case may not be considered "work related" under the statute, but may meet OSHA recording criteria, and vice versa.

8. Which is true regarding measurement of employee productivity?
A. Piece work and time and motion studies work just as well in the service sector as in manufacturing environments.
B. Self-report measures are costly and difficult to administer.
C. Self-report measures are appropriate for most jobs that do not produce a concrete work output.
D. Use of "dashboard" formats is not recommended.

Answers: 5. D; 6. A; 7. D; 8. 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 the June issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■