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Wound care program keeps patients safe, out of hospital

Health plan collaborates with vascular surgeons, home health nurses

A team-oriented approach to working with members with non-healing wounds has paid off for UPMC Health Plan and its network providers.

In April 2010, the last period for which data are available, almost 89% of non-healing wounds achieved optimal healing response within eight weeks, says **Roseann DeGrazia**, RN, BSN, MEd, senior director, medical management for the Pittsburgh-based health plan.

The UPMC Wound Care Program is a collaborative effort between UPMC Health Plan, University of Pittsburgh Physicians Division of Vascular Surgery, the UPMC Center for Quality Improvement and Innovation, UPMC/Jefferson Regional Home Health LP, and the UPMC Wound Healing/Limb Preservation clinic.

The project's goal is to increase the healing rate of wounds and increase quality of life for members with non-healing wounds, DeGrazia says.

"As a health plan, we work collaboratively with our network providers on ways to improve care for our members. One of the areas we're interested in is wound healing. We decided to work with our vascular surgeons and the home care agency to manage members with chronic, non-healing wounds," she adds.

Members who have non-healing wounds with a duration of four weeks or longer are eligible for the program.

The program is designed to facilitate state-of-the art treatment for chronic wounds in the home care setting. Wound care specialists and UPMC Health Plan wound care case managers collaborate with the member's primary care physician on a treatment plan for the patient's wound. UPMC vascular surgeons review the wound information and treatment plan and offer suggestions to the treating physician.

"The goal of the program is to increase the healing rate by 50% in four weeks. If patients are on a healing trajectory after four weeks, the results will show. If not, the physician can change the treatment plan," DeGrazia

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says.

The health plan identifies many members for the program when they are hospitalized with non-healing wounds as a primary and secondary diagnosis. Other referrals come from physicians, home health agency nurses who are treating a different condition, and UPMC's case managers who may be working with members for a different reason and learn that they have a non-healing wound.

When a patient is referred to the program, **Lori Painter**, RN, BSN, CCM, wound care case manager for UPMC health plan, accesses the patient record and compiles a thorough medical history including medications and any co-morbidities.

The health plan has an integrated system, which allows the case manager to access utilization management information in the hospital, clinical data from claims, laboratory data and lab results, and pharmacy data, including what drugs were prescribed and when the patient filled them. Painter can leverage the information to help engage patients, DeGrazia says.

More than 40% of patients in the program have diabetes. Others have peripheral vascular disease or other conditions that compromise their blood circulation.

Painter calls patients referred to the program, finds out if they are interested in enrolling in the program, and if so, arranges for a specially trained wound, ostomy, continence nurse (WOCN) to visit the patient in his or her home.

"I do a thorough history of their social system. I find out if they have significant others or friends in the community to help care for them and if they live in an area where they have difficulties getting to their physician office," she says.

The program is optional for patients. If they opt out when Painter calls, she gives them information and the program phone number. If the patient ends up back in the hospital for wound treatment, then Painter initiates another outreach call.

"If the primary care physician recommends the program to patients, they're more likely to participate. We work closely with the primary care providers to keep them informed about the program, publishing information in our provider newsletter and attending their meetings," DeGrazia adds.

The patients have the option of having a home care visit, talking to the nurse, and then opting out of the program, but most choose to stay in the program, DeGrazia adds.

"We take a high-touch approach to wound care. Our patients are very satisfied with the program," she says.

Specially trained enterostomal nurses employed by the home care agency assess the patient in the home, then visit every two weeks, or more often, depending on the wound.

The nurse takes measurements and photographs of the wound and performs a Doppler study on the first visit to determine if vascular problems may be interfering with the healing. If so, she contacts the patient's primary care provider for a referral to a vascular surgeon in order to facilitate early intervention.

The nurse uses a special wound care photo

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information form to record the type of wound, the height and depth, type of drainage, and the treatment protocol, DeGrazia says.

The wound care nurse sends photographs and measurements of the wounds every few weeks to Painter, the primary care physician, and the vascular surgeons group, which oversees the program, DeGrazia says.

The UPMC vascular surgeons review the wound photo information form in order to assess the progression of healing and offer recommendations for change to the wound care protocol as needed, she says.

The primary care physician is responsible for the management of the patient and takes into consideration the input from the wound care photo information form, the home care WOCN nurse, and the wound care reviewing vascular surgeon. Changes to the wound care treatment protocol are made only as ordered by the primary care physician, she says.

If the wound doesn't improve within a certain time, the reviewing vascular surgeon may recommend a change to the wound care treatment as per the protocol, DeGrazia says.

Painter is involved in transitioning patients from the hospital to home, enrolling the patients in the program, and letting them know when the home care visit is scheduled.

She collaborates with the WOCN nurse to make sure the patient understands everything he or she needs to know for self-care, such as how and when the dressing should be changed and what medication should be applied in between visits from the nurse, she says.

She makes sure the patients understand their condition and their discharge instructions and answers any questions they may have. In some cases, she may need to clarify the treatment plan with the physician, she says.

She communicates with the home care agency nurse by telephone and by e-mail and calls patients frequently, usually weekly or bi-weekly depending on the patient's preferences and condition.

When she calls patients, Painter conducts a medication review, making sure the patients got their prescriptions filled, going over the medications and when and why they should be taken, and helping patients understand why they may need to take multiple drugs, she adds.

If the patient is a diabetic, she educates them on the disease process and enrolls them in the health plan's diabetes program.

"I educate them on the importance of checking their blood sugar and taking their medication as directed. I explain that elevated blood sugar can cause healing to slow down and make sure they are getting enough protein in their diet to help with healing. If they are having trouble controlling their blood sugar, I contact the primary care provider to discuss treatment, including the need for further evaluation by a diabetes specialist," she says.

"The wound care case manager is the key contact for the patient while the patient is in the program. When the wound heals, she transitions the patient to a disease management health coach for ongoing support in keeping his or her diabetes under control," DeGrazia says.

Managing the care of the patients is a team effort, Painter points out.

"If I find patients are having difficulty getting in to see the doctor or have problems paying for their treatment, I can get the health plan's social worker involved. The pharmacist who is embedded in the care management department is available to conduct a medication review or assist with pain management," she says.

One patient wasn't going for follow-up visits because she couldn't afford her copay. Painter alerted the social worker who helped the woman sign up for charity care to help with the copays.

If the patient is having trouble with general medical care, Painter can call on the health plan's mobile case manager to go into the home and assess the situation.

"I have a network of people I can call on to enhance the quality of life for these patients. We work as a team to look for ways to avoid repeat admissions and complications including pain management issues," she says.

She conducts a depression screen on all the patients and refers appropriate patients who agree to the health plan's behavioral health program.

For instance, one patient who was facing an amputation told Painter he was afraid and didn't think he could handle losing his limb. She called in the home care behavioral health nurses who visited him in the home and helped him learn to cope with the changes to his daily life.

The wound care team takes a holistic approach to treatment, Painter says.

"At UPMC, our job is not just to take care of the wound. We try to involve the patient, the whole family or caregiver, and the community in helping people maintain their health," Painter says.

For instance, when Painter called one patient

to remind him of his appointment with a vascular surgeon, the man told her he couldn't go because he was out of colostomy supplies. Painter called the home health agency, which put out a bulletin to the nurses serving the patient's area, and one of them brought extra colostomy supplies to the patient's home.

The wound care nurses and Painter meet at least quarterly and discuss the individual members enrolled in the wound care program wounds. The team addresses any barriers to healing. The team meets regularly with the vascular surgeons to go over the patient records and treatment plans.

"As a payer, we have a lot of information that can be useful to the integrated care team. We know the utilization data, including claims, and pharmacy data. In addition, our case managers and social workers know the psychosocial history of these patients and can collaborate on the plan of care during case conferences," DeGrazia adds.

Members of the wound care team get to know each other very well and are very familiar with the patients, their wounds, their treatment plans, and their progress, DeGrazia says.

The team reviews the wound care protocols annually to determine if there are new products or new treatments that may benefit the patients, she says.

Patients are discharged from the program when their wound is healed. The case manager gives discharged patients a number to call in case they have any problems.

Before starting the program, DeGrazia, Painter, network managers, a representative from the home care agency, and one of the vascular surgeons met with provider groups who have the highest volume of UPMC Health Plan members, educated them about the program, and asked them to refer their patients who have non-healing wounds to the program, DeGrazia says.

They also met with the vice president of nursing, director of case management, wound care teams, and the utilization management department at hospitals in the network and shared information about the wound care program.

After successful pilots with the wound care program, UMPC Health Plan and Home Health shared their expertise with other health plan network home care agencies.

"We have contracted with our home care agency, UPMC/Jefferson Regional Home Health LP to conduct training for participating network home care agencies interested in the wound care program," DeGrazia says. ■

CMs guide seniors through EOL processes

They provide education, support

Seniors covered by BlueCross BlueShield of Tennessee's Medicare Advantage plan are guided through the end-of-life processes by case managers who empower the members with the education, resources, and assistance they need to make their own decisions about what kind of what kind of care they want to receive at the end of life.

The Chattanooga-based health plan end-of-life planning program received a bronze award from URAC at the Best Practices in Health Care Consumer Protection and Empowerment awards ceremony last fall.

The program began in 2009 after the health plan started its Medicare Advantage program in 2006, says **Alice Greer**, RN, BSN, CPHQ, quality research analyst in quality management, who was a case manager at the time.

"As we worked with the Medicare population, we realized that end-of-life concerns are a big issue. We found that even though some of the members knew they were facing a potentially terminal illness, they hadn't thought about end-of-life plans, or if they had, they didn't have a legally appropriate form or had not shared their wishes with their family or their physician," Greer says.

At the same time, the insurer determined that many staff members were uncomfortable initiating a conversation about end-of-life considerations and needed education to learn how to approach members about their choices.

"We looked for ways to assess our Medicare population to identify people who needed the program and to aid the case managers in bringing up the subject with members and leading them through the process," she says.

The case managers who work with the Medicare Advantage members have all been trained on how to approach the subject and have information at their fingertips to help them educate the members, she adds.

The health plan also collaborated with the non-profit Tennessee End-of-Life Partnership and sponsored a day-long educational program for case managers and the health plan's community of providers.

When seniors sign up for Medicare Advantage, the health plan sends them the health needs

assessment. They can return it by mail and have it scanned into the computer program, or they can call and complete the assessment over the telephone.

Referrals come from the health needs assessment, from the utilization management department, from claims data that show members with multiple hospital admissions, and from the health plan's predictive modeling.

"CMS requires Medicare Advantage to conduct an initial health needs assessment. We tweaked our assessment and configured our computer system so it would automatically send out a referral when someone had a condition that indicated they might benefit from an end-of-life discussion," Greer says.

Any Medicare Advantage member who is referred to case management is asked if they have end-of-life plans, and if they would like to discuss the subject. Those who meet the criteria for needing immediate end-of-life support are offered a more intensive care plan, Greer says.

Criteria for the intensive care plan include debility, failure to thrive, cancer patients with a terminal diagnosis or uncontrolled symptoms, advanced heart disease patients, advance pulmonary diseases, dementia, end-stage liver or renal disease, and neurological disorders such as stroke, Parkinson's disease, and amyotrophic lateral sclerosis.

The utilization management department has a trigger list of criteria. If someone calls to get approval for a procedure and the patient falls into one of the diagnosis categories, those nurses are trained to send a referral to a case manager, she says.

The case managers make outreach calls to all members who are eligible for the intensive care planning program.

They start by explaining the services the health plan offers, what the role of the case manager is in end-of-life planning, and what they can do to empower the member to make their own decisions.

If members consent to participate in the program, the case manager completes a thorough assessment that includes their current health status, their present functional status, what resources they have, who their caregivers are, their understanding of their current level of health, diagnosis and prognosis, information on their socioeconomic status, and any educational or language barriers they may face.

"The case managers can mail materials to the member or provide Internet resources. We go so far as to help them prepare their forms if they know what they want and don't know how to get the Tennessee state-approved forms," she says.

The Medicare Advantage staff include two social workers who help people complete the forms over the telephone or, if the member prefers, will meet with them at the health plan's Silver Life Center.

The case managers get consent to notify the member's primary care provider and collaborate with the physician as well as the caregiver so everyone is on the same page about the member's end-of-life choices.

When the case manager conducts the assessment, the software system automatically triggers an appropriate end-of-life plan based on the answers the member gives to questions. The care plan includes automated talking points that pop up on the screen.

For instance, if the member says he hasn't made end-of-life plans and doesn't know what is available, the case manager can click on a list of advanced directions with a concise explanation of each.

The assessment and care plan is available in the health plan's software for case managers in other areas of the company and other lines of business to use. The specific assessment is geared to the senior population, but the care plan is appropriate for any age, Greer says.

When developing the care plan, the case manager helps members make all choices from all the options available, such as where they want to receive care, symptom management, bladder control, and issues such as mobility, safety, comfort, and pain. They discuss caregiver needs and stresses, and services needed at home if the member chooses to stay at home.

The case management team spends a lot of time educating members about hospice care and palliative care and the difference between the two, she says.

One of the goals of the end-of-life program is to overcome the negative impression many older people have of hospice care by educating them. Some members aren't aware of the hospice benefits they have. Others don't take advantage of them because of their perception of what hospice means, Greer says.

"Length of stay in hospice is incredibly short with our Medicare population. If somebody doesn't get into hospice until the last two days of their life, they've lost the opportunity to increase the quality of life, have gone through unnecessary procedures, and increase the stress on the family. Knowing about hospice and what it means saves

people a lot of panic-mode trips to the emergency room for interventions and makes them feel more in control," she says.

As they work with the members, the case managers stress the importance of collaborating with their health care providers so the treatment team will be aware of the patients' wishes.

If patients agree to participate in the program, the case manager follows them and contacts them at least every 30 days. The patient and family members have a telephone number they can call to talk to the case manager at any time.

Patients who enroll in the program stay in the program until they decide to drop out or they pass away.

Before the program began, case managers documented a discussion with members on end-of-life issues only 58% of the time. After the training, the figure went up to 99%.

"It's hard to measure outcomes in a program like this, but we know we are making a difference because we get a lot of letters from family members after the death of a loved one, thanking us for the case manager's support. They tell us how grateful they were that the case manager support alleviated their hesitancy to accept hospice care and that their loved one was able to die at home where they wanted to be.

"We also get positive feedback from the members themselves who really appreciated being educated and empowered to make their own choices and to make sure their wishes are followed. Some are chronically ill but may still have years left, and it makes them feel good to know they have taken care of business, so to speak." Greer says. ■

Post-discharge visits reduce rehospitalizations

MD or nurse practitioner visit patients' homes

Members who received a post-discharge visit from a physician or a nurse practitioner experienced 20% to 30% fewer readmissions than patients who received only telephonic care management during a pilot project by XLHealth, a Baltimore-based provider of health plan solutions for Medicare beneficiaries with special needs, according to **John Mach**, MD, XLHealth's chief medical officer.

Now that the pilot is complete, the health plan is working with its contracted community nurse practitioners and physicians to expand the program to the entire service area and will continue to focus on patients at highest risk, he says.

The program aims to reduce unnecessary and costly readmissions among the high-risk members of Care Improvement Plus, XLHealth's Medicare Advantage plan, says Mach.

"Far too many seniors with chronic conditions have repeat hospitalizations, causing an out-of-control revolving door. As a health plan that focuses on these people, we are stepping up our efforts to make sure our members are getting the follow-up care they need to break this cycle," he adds.

The initiative follows the success of XLHealth's HouseCalls program for members with chronic illnesses. The health plan's network of 240 doctors and nurse practitioners completed more than 80,000 HouseCalls visits to at-risk members last year and expects to complete more than 6,000 post-discharge visits by the end of 2011, Mach says.

"This program is a natural extension of our HouseCalls program. It has been so successful, we were looking at ways to utilize the capacity of the nurse practitioners and physicians with whom we contract. The natural place was the transitional care issue. This is one of the many ways we are expanding our ability to support members in their homes at times when they most need our help," Mach adds.

The health plan experimented with using home health nurses during the pilot project but determined that the physicians and nurse practitioners were more effective in assessing members who have complex medical needs.

Since the health plan already contracted with doctors and nurse practitioners for its HouseCalls program, the decision was made to use them for the post-discharge visits, Mach says.

"The nurse practitioners and physicians were able to get to the patients' homes in a more timely way, completed more visits, and had slightly better results. The difference in cost of using the more highly trained clinicians was not a significant deterrent. All of these patients need specialized care, and medication is a critical issue," he says.

The community-based clinicians who visit the patients in their home work closely with Care Improvement Plus' care management team and the patients' primary care physicians to ensure that the patients get everything they need to stay healthy at home and avoid emergency department visits or readmissions.

About 75% of the health plan's members live in rural areas and 30% do not have a medical home, Mach pointed out.

"The program is particularly beneficial for members who are in locations that may not have robust transition of care processes. The doctors and nurses step in and provide that coordinated post-discharge education and care," he says.

Members in the pilot project were at highest risk and were in selected service areas. Half were randomly chosen to receive the home visits. The remainder were assigned a telephonic case manager.

When members who are stratified as high risk are hospitalized, the health plan utilization nurses notify the community-based physician or nurse practitioner so he or she can schedule a visit within a few days after the patient gets home.

"People who are in our low-risk categories often are hospitalized with a stroke or a new condition. Our utilization nurses are trained to identify people who change risk categories and assign them to a care manager and arrange a visit from a physician or nurse practitioner," he adds.

When they visit a member's home, the clinicians fill out a structured interview form, which has room for additional information. They send the information back to the care manager, who enters it into the health plan's care management system where it is available throughout the health plan to anyone who has contact with the member.

"The doctors and nurses act as our eyes and ears in the home. They take a close look at the medicine bottles, pick up on environmental issues or family issues, and take a good look at the member to see all of his or her conditions and capabilities," Mach says.

They make sure that the patients have filled their prescriptions, that home care visits have been scheduled, and that the necessary medical equipment has been delivered.

They alert the plan's care managers if equipment is missing or the patient hasn't heard from the home care agency. Any medication issues are identified and brought to the attention of pharmacists, who can conduct in-depth medication counseling sessions with members as well as reach out to the members' pharmacists and providers on recommended therapy adjustments, Mach adds.

The doctors and nurse practitioners make sure that the members understand their post-discharge plans, that they have a follow-up appointment with a primary care provider, and that they understand their medication regimen.

"The health care system is fragmented, and often patients receive medication changes while they are in the hospital. The discharge medications don't always correlate with what is in their home and patients are confused about which to take. There's a long list of reasons why medication becomes the central focus. The value of using nurse practitioners and doctors in the program is that they are very astute in terms of medication management," Mach says.

The clinicians inform the care manager about any long-term issues the patient may face.

Occasionally, based on the fragility of members, the care manager will schedule another visit by nurse practitioner or communicate with the member's primary care physician.

"We take the information we have and get it back to the primary care physician, either electronically or by telephone if it's urgent," he says.

The clinicians spend about an hour at the members' homes, providing support and education, and going over the medication regimen.

"These people are still relatively sick, and it may not be the optimal time to coach them on lifestyle issues. A few weeks out, when they are more stable, the care managers will begin to work with them," he says. ■

Data driven: Using data to lower care costs

The 'point where health, safety, sustainability meet'

Are rising health care costs a worry at your workplace? Occupational health professionals would be wise to look at the role they can play in getting them under control, according to **Margie Weiss**, PhD, CEO and community health advocate at the Weiss Health Group, a Neenah, WI-based consulting company that works with companies and communities on health and wellness.

"Employers are faced with an aging workforce, bringing an increased incidence of chronic disease," notes Weiss.

A data-driven strategy is one way to successfully lower health care costs, according to a study which identified drivers of health care costs. The researchers included both direct and indirect costs, such as doctor visits, prescription drugs, absenteeism, disability, and productivity.[1] These data can then be used to develop

appropriate interventions, prevention programs or case management for employees with specific diseases, they reported.

"Data should drive your decision-making," says Weiss. "Integrate health care costs, workers' compensation care costs, and sustainability-related metrics."

Healthy workers and their families are likely to incur lower medical costs and be more productive, while those with chronic health conditions generate higher costs in terms of health care use, absenteeism, disability and overall reduced productivity, says Weiss.

"Occupational health is the connecting point where health, safety and sustainability meet," says Weiss, pointing to increasing evidence that health promotion programs are cost-effective.

For example, include data on health care costs, health risk assessments, biometrics, presenteeism, workers' compensation costs, incident tracking, near-miss tracking, absenteeism, ergonomic assessments, employee needs and interest surveys, and worker demographics, she says.

"Workplace injuries and work-related illnesses can be a huge financial burden for employers," says Weiss. "Economic costs of occupational illness and injury match those of cancer, and nearly match those of heart disease."

Make your case

Kathy Dayvault, RN, MPH, COHN-S/CM, an occupational health nurse at PureSafety in Franklin, TN, notes that according to the Centers for Disease Control & Prevention (CDC), there are four causes of chronic disease that are modifiable:

- lack of physical activity
- poor nutrition
- tobacco use
- excessive alcohol consumption.

"These four modifiable factors are responsible for illness, suffering and early death related to chronic disease," she says. Dayvault also notes that the three leading causes of death in the U.S. are heart disease, cancer and stroke. "Heart disease and stroke are among the most widespread, costly and preventable health problems in the U.S. today," she says. Dayvault adds that the cost of heart diseases in 2010 was "astronomical," with coronary heart disease at $177.1 billion; hypertensive disease at $76 billion, stroke $73.7 billion and heart failure at 39.2 billion.

"Using the above data, you can successfully make a case for addressing chronic diseases in the workplace," she says.

One tool that can help you do this, says Dayvault, is statistical data from health care insurers. Utilize this information about the health of the workforce, she advises, to determine the chronic conditions that are prevalent in the workplace.

"Through insurance data, health care costs for specific chronic conditions can be determined," she adds. After you've reviewed this statistical data, Dayvault says that you can then determine specific ways to address worker health through wellness initiatives and disease-specific programs.

"The impact of preventing and controlling hypertension and elevated cholesterol are key to cardiovascular health," says Dayvault. She points to CDC statistics that a 12 to 13 point reduction in systolic blood pressure can reduce heart disease risks by 21%, stroke risks by 37% and risk for death from heart disease or stroke by 25%.

"Another case for workplace wellness programs is addressing diabetes, and diabetes risk indicators," says Dayvault. In 2007, the national economic burden of pre-diabetes and diabetes was $218 billion, she notes, and of that amount, $65 billion was associated with reduced productivity.

This loss of productivity was determined to be a result of higher levels of absenteeism, working at less than capacity and early mortality, she says.

"These examples are strong cases for occupational health," Dayvault adds. "A little homework on the financial impact of disease and disease prevention can catch the attention of the CEO. It can increase their understanding of the ROI which can be realized from instituting wellness programs in the workplace."

REFERENCE

1. Bunn WB III, Stave GM, Allen H, et al. Evidence-based benefit design: toward a sustainable health care future for employers. *J Occup Environ Med.* 2010; 52(10):951-955.

[For more information on using data to reduce health care costs, contact:

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Better tools needed to measure presenteeism

Advocate for positive changes

More reliable tools are needed to measure the costs of presenteeism, which takes an insidious toll on the work place.[1]

"We were struck by the variation in results by other researchers using different self-report tools," reports **Dee W. Edington**, PhD, director of the University of Michigan's Health Management Research Center in Ann Arbor, MI. "That concern led us to examine the sources of the variation."

Edington says that he was surprised to find "disturbing issues" at each level of analyses: measurement, conversion from measurement to a unit of presenteeism, and translation of presenteeism to a financial unit.

"It would benefit researchers and health professionals if there were more transparency, common metrics between instruments, and increased reliability and validity," says Edington.

According to Edington, your best option is to use a company-generated performance scale. "If the company does not have a measure, then I would use any of the current self-reported measurement scales," he says. "However, I would be cautious about quantification, since we don't know the truth at this time."

In general, those individuals with more risk factors or with a disease have more lost time at work, says Edington. "We have also shown that when risk factors change, presenteeism changes in the same direction," he adds.

More than medical costs

Presenteeism costs are estimated to be greater than the cost of absenteeism, and represent up to 60% of all costs of mental and physical illnesses, notes **Diane Lack**, RN, MS, CCM, cardiology case manager at the University of Michigan Health System's Cardiovascular Center in Ann Arbor.

"Costs related to presenteeism are greater than the direct health costs for ten of the most costly health conditions studied and accounted for 18 to 60% of all health care costs," says Lack.

Lack says that employers do not fully consider the fact that expenses related to presenteeism losses are, for the most part, greater than actual medical costs.

"Presenteeism impacts individuals and organizations, affecting quality of life and health," says Lack. "It leads to increased health care costs, increases in occupational accidents related to distractibility, and deterioration of service and product quality."

Lack says that there is an opportunity for occupational health nurses to determine the significance of presenteeism, and its effect on the physical and psychosocial well-being of individual workers.

Obtain information through careful measurement of presenteeism using the appropriate tools, she says, and use this to develop interventions. Here are Lack's recommendations:

• Target wellness and disease management programs to the specific needs identified.

Your goal should be "increased health and health maintenance," says Lack.

• Be a strong advocate for positive changes in workplace policies.

"Promote flexibility for workers providing dependent care and for the special needs of aging workers, and provision of appropriate health care," says Lack. Another important goal, she says, is to "strive for mental health destigmatization, and recognition and treatment for mental health disorders and stress reduction."

• Implement a work culture that promotes self-care and rest.

"This minimizes exacerbation of symptoms, and prevents the spread of illness to co-workers," she Lack.

• Invest in wellness.

"Declines in productivity related to presenteeism could be offset by small investments in screening, education, and treatment," says Lack. "Studies do show that, globally, the return on investment for wellness programs is increasing." *(See related story, next, on use of data to measure productivity.)*

REFERENCE

1. Brooks A, Hagen SE, Sathyanarayanan S, et al. Presenteeism: critical issues. *J Occup Environ Med.* 2010; 52(11):1055-1067.

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Use data dashboard to gauge productivity

Take an integrated approach

"Presenteeism is a measure of productivity. It can be gauged in a number of ways," says **Margie Weiss**, PhD, CEO and community health advocate at the Weiss Health Group, a Neenah, WI-based consulting company that works with companies and communities on health and wellness.

The most frequently used metrics, says Weiss, are absenteeism statistics and Health Risk Assessment (HRA) responses. "One of the best mechanisms for occupational health care providers is a data dashboard that can be updated on a regular basis," says Weiss.

Dashboard components should be linked back to HRA results, health care costs, Employee Assistance Program use rates and Occupational Safety and Health Administration (OSHA)-recordable data, says Weiss.

Weiss says that confounding variables are a challenge when it comes to measuring presenteeism. For instance, an absenteeism rate could be the result of policy changes, effective employee health programs, or cleaner indoor air, she says.

"A great example is a decrease in smokers in the workplace, which could be due to 'no smoking' policies, support services such as counseling, or public policy changes," adds Weiss.

Another challenge, says Weiss, is the fact that HRA presenteeism statistics are the result of self-reported information. "One example of more quantitative testing would be biometric screening, such as blood pressure, percentage of body fat, and nicotine levels," notes Weiss.

A drop in absenteeism may coincide with the implementation of a new wellness program, but how do you know if the two events are linked? "It is sometimes hard to ascertain whether a new policy, health and wellness initiative or facility renovation results in increased productivity, less absenteeism or improved scores on HRA reports," says Weiss.

For this reason, it is important that occupational health care providers use a "triangulated approach" to measuring and reporting presenteeism.

Quantitative statistics, such as sick days, days worked and OSHA–reported absences, must be evaluated in conjunction with more subjective data, she explains, such as responses to items on HRA questionnaires.

"These metrics must also be tied to other financial metrics which measure business activity, such as sales or production revenues," says Weiss.

Many types of employment have no objective ways to assess employee performance and productivity, says **Diane Lack**, RN, MS, CCM, cardiology case manager at the University of Michigan Health System's Cardiovascular Center in Ann Arbor.

"Self-reported measurements, especially with short recall periods of one or two weeks, can be vital sources of information in health promotion programs," says Lack. These provide high validity and reliability for measuring health risk as well as planning, implementing, and assessing interventions, she notes.

Lack says that an integrated approach to health and productivity improvements is the best strategy to decrease presenteeism.

However, she notes that research indicates that the complex nature of presenteeism, and uncertainties that still surround its measurements, warrant caution while translating measurements into monetary value.[1]

"There is no consensus regarding how best to measure, quantify, and evaluate productivity costs," Lack explains. "Inordinate emphasis on projected cost analysis should be discouraged, while standardization of presenteeism measurements should be encouraged."

REFERENCE

1. Cyr A, Hagan S. Letters to the editor: Measurement and quantification of presenteeism. *Jrl Occ Env Med.* 2007;49: 1299-1301. ■

Find the right balance for wellness incentives

A fun, fair approach is best

Incentives for wellness program participation is becoming more common, but "it can be challenging to settle on the optimal design," according to **Daniel Buckalew**, a health coaching program manager for Minneapolis-based Ceridian, a global business services company.

"Some corporate leaders feel they shouldn't have to pay people to practice a healthy lifestyle, even though they understand the impact unhealthy employees can have on the bottom line," says Buckalew. "This opinion is understandable, but it would be shortsighted to ignore incentive programs altogether."

Incentives can increase utilization of available

programs and services, says Buckalew, adding that they have not typically been proven to directly improve health outcomes.

However, you must get adequate utilization and engagement before you can get the desired return on investment, he adds. "This is where incentives come in," says Buckalew. He recommends these approaches:

• Don't offer only low-value incentives.

"Incentive plans that only provide low-value rewards, such as T-shirts and water bottles, don't dramatically increase participation," says Buckalew. "Incentives must be of a certain value to have a significant impact."

The potential for total annual rewards in amounts of $100 or more, "is much more successful in driving higher engagement," he says.

• Carefully consider the perceived fairness of the incentive being offered.

"Some employees may view it as unfair if they don't feel there is an equal opportunity to earn the incentive," says Buckalew.

For instance, a program mimicking "The Biggest Loser" with a higher-value reward needs to consider those who are already at an optimal weight, he explains, and therefore don't have an opportunity for that reward.

• Hold competitions between departments, business units, or work sites.

"This can add an element of fun, and may promote teamwork," he says.

• Recognize individuals.

"Featuring names and pictures of high-level participants or those individuals who achieved significant goals in company newsletters or Intranet sites, can be motivating," he says. "However, be sure to get permission, as not all employees may agree to this."

Some companies are now taking the opposite approach to incentives, says Buckalew, by implementing a surcharge on health insurance coverage for unhealthy behaviors such as smoking. Although this can be successful in motivating some employees to attempt to quit, it may have other negative impacts that aren't easily measured, he warns.

These may include distrust and negative feelings toward the employer, and decreased morale, says Buckalew. "A better approach might be to discreetly raise premiums for all, then offer sizable refunds to those who practice healthful behaviors and achieve specific outcomes," he suggests. "This approach may be considered more fair, but may take more resources to administer."

Buckalew says to consider linking participation in programs to prize drawings. The more an employee participates in an exercise, nutrition, or smoking cessation program, for example, the more chances he or she will get toward a grand prize drawing.

"Those who achieve specific goals might also get more chances than those who just participate, but don't achieve goals," he explains.

Buckalew says that above all, your incentive program design should be an integral part of the organization's health promotion strategy, and should be closely aligned with the marketing and communication plan. "This is a critical component," he says. "Without adequate utilization, even the best designed programs will not produce the outcomes or ROI desired." ■

COMING IN FUTURE MONTHS

- New employment opportunities for case managers
- How to deal with the diabetes epidemic
- Coordinating care through the continuum
- Ways to engage the at-risk population

CNE QUESTIONS

9. UPMC Health Plan members who have non-healing wounds with a duration of four weeks or longer are eligible for the UPMC Wound Care Program.
A. True
B. False

10. When did BlueCross BlueShield of Tennessee's begin it's end-of-life planning program?
A. 2006
B. 2007
C. 2008
D. 2009

11. Members who, as part of a pilot project by XL-Health, received a post-discharge visit from a physician or a nurse practitioner experienced 80% fewer readmissions to the hospital than patients who received only telephonic care management.
A. True
B. False

12. Which is true regarding measuring presenteeism in the workplace?
A. It is not advisable to use a company-generated performance scale or self-reported measurements.
B. The number of risk factors an individual has is not linked in any way with presenteeism.
C. Information on presenteeism should be obtained through careful measurement using the appropriate tools, and used to develop interventions.
D. Costs related to presenteeism are estimated to be far less than the cost of absenteeism.

Answers: 9. A; 10. D; 11. B; 12. 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. ■