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Covering Case Management Across The Entire Care Continuum

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Educate yourself to manage care for a growing senior population

Opportunities, challenges abound for case managers

As the baby boomers reach retirement age, the senior population in this country is growing by leaps and bounds. By 2030, the United States will have an estimated 72.1 million older adults, representing a growth of almost 20% says **Anthony J. Balsamo**, MD, orthopedic surgeon and director of the Geriatric Fracture Care Program at Geisinger Wyoming Valley Medical Center in Wilkes-Barre, PA.

An increasing number of people are going to need help managing chronic diseases, accessing community resources, and navigating the complicated healthcare system. This change brings opportunities for case managers, but it also means challenges in providing the kind of care coordination that the senior population needs.

"Healthcare spending already consumes more than 17% of the gross national product. We've got to provide evidence-based cost-effective medical care for this large generation of seniors who are coming along and the care has to be coordinated to get them in and out of the hospital and living safely in the community as rapidly possible," Balsamo says.

The needs of the elderly are different from those of younger patients, and the entire process of care is different for them, says **Moreen Donahue**, DNP, RN, chief nurse executive and senior vice president of patient care

Get ready for the aging of America

The baby boomers are growing older, and this means a tremendous influx of senior citizens with significant healthcare needs. Case managers are going to be needed more than ever to manage the care of this huge population, but they also need to understand the special needs of senior citizens and take them into consideration as they tailor care plans. In this issue of *Case Management Advisor*, we look at how managing care for seniors differs from managing care for younger patients. We'll look at how a geriatric fracture care program cuts hospital lengths of stays by 2.1 days, how home visits to high-risk seniors after discharge resulted in a 195% return on investment, and give details on a telephonic case management program that eases the transition from hospital to home.

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services at Danbury (CT) Hospital. After receiving a federal grant, Danbury Hospital developed a family-centered geriatric nursing care curriculum to give its nurses and case managers the skills and competencies to care for its growing elderly population. "Many nurses completed their training before the nursing curriculum included geriatrics and providing care for the elderly as a specific population," Donahue says. "This course offers our nurses and case managers an opportunity to increase their knowledge in caring for an increasing population of older patients."

As they develop a care plan for the elderly, case managers must understand the specific needs and limitations of their patients and take them into account when creating a discharge plan. Elderly patients might experience failing eyesight, loss of hearing, and problems with their balance. Many have cognitive issues and physical mobility problems. Being away from the home setting and in the hospital is disorienting for them. "Case managers need the expertise to plan for an appropriate level of care for seniors and to help their families make the best decisions," Donahue says.

Because elderly patients often have trouble comprehending and retaining information, case managers should involve the family in plan of care and the discharge instructions, Donahue advises. Often this involvement means that hospital case managers need to do more frequent rounding and be available when the family can be there. They can make sure the patient understands the medication regimen. "When they work with older patients, case managers have to become more flexible in meeting the needs of the patient and family members," Donahue says.

Many times when the elderly have an acute event that results in a hospital admission, their next level of care is different from the level of care before hospitalization. Often the elderly person needs additional assistance after discharge and telephonic care coordination interventions to make sure they adhere to their treatment plan.

Seniors who are living at home often need more support than younger patients to ensure that they can continue to live safely in the community, adds **Diana Lehman**, RN, BSN, CHIE, director of case management for Independence Blue Cross in Philadelphia. "The Medicare population tends to have more comorbidities than commercial members, and their condition is complicated by complex polypharmacy issues. They are often confused about their medication and need help in following

EXECUTIVE SUMMARY:

As the senior population grows, case managers need to understand the senior population in order to develop effective care plans.

- Many seniors have failing eyesight, diminished hearing, and mobility issues.
- Cognitive abilities decline as people age, sometimes making it difficult to manage medication or understand treatment plans.
- Case managers often need to involve family members in the plans, which is a significant challenge if they live out of town.

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EDITORIAL QUESTIONS

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

their treatment plans. They are overwhelmed by all the instructions they get in the hospital and often need assistance with transportation to physician visits," she says.

Because of the unique needs of the senior population, case managers and social workers at Independence Blue Cross work exclusively with Medicare patients and carry a smaller caseload than case managers who work with the commercial population. "The frequency and intensity of interventions is greater with the Medicare population. They need more community resources than younger patients, and our case managers often have in-depth discussions about their medication regimen and how to follow their treatment plan, Lehman adds. *(For details on Independence Blue Cross' Transitional Case Management Program for Medicare members, see related article on p. 90.)*

Case managers need to understand how the events that result in hospitalization could have affected the senior's physical mobility and cognition, and they should take that issue into consideration when they create a discharge plan, Donahue says. "Lengths of stay are getting shorter and shorter. This means case managers must have the expertise be able to quickly assess the specific needs of the elderly and get a plan in place to address those needs," she says.

Older patients might experience reactions to drugs that don't affect younger patients, Balsamo says. For example, older patients taking hydromorphone for pain management might become groggy and disoriented, with an increased risk of falls. If they have to stay in bed because of the disorientation, they can lose muscle tone and develop pressure ulcers, prolonging or impeding their recovery. *(For details on Geisinger Wyoming Valley Medical Center's specialized care for senior orthopedic patients see related article, at right.)*

If elderly patients are being discharged back to home, especially when they live alone, case managers should educate them and their family members about the importance of good lighting, remove scatter rugs to prevent falls, and install hand rails in the bathroom, says **Patti Dorgan**, LCSW, ACSW, director of direct services for the Pima Council on Aging in Tucson, AZ.

In situations in which the seniors' family members live in a different state, case managers often need to provide a great deal of support to the senior and his or her family, Dorgan says. "The whole healthcare system is difficult to navigate, particularly for seniors. Most seniors and their family members don't know the whole range of community resources that are available to them," she says.

The Pima Council on Aging offers workshops for caregivers in which they teach them medical advocacy, how to take charge of their loved one's care, and how to navigate the system to find their elderly relatives the care they need, Dorgan says. The organization has a caregiver support program, staffed by social workers who help families access community services. If appropriate, they refer the families to a caregiver specialist who provides individual care coordination.

"We educate the families on the options available and help them decide what options will work best for their loved ones," Dorgan says. "Many seniors don't want to ask for help, particularly the generation that grew up during the Depression. They look on it as government assistance. There are a lot of wonderful programs available to help them with their daily needs, but they need help in accessing them." ■

Fracture program cuts LOS by 2+ days

Multidisciplinary team caters to elderly

Just six months after Geisinger Wyoming Valley Medical Center in Wilkes-Barre, PA, began its Geriatric Fracture Care Program, the average length of stay (LOS) for seniors having orthopedic surgery for fractures dropped from 7.2 days to 5.1 days.

Anthony J. Balsamo, MD, orthopedic surgeon and director of the Geriatric Fracture Care Program, attributes the drop in LOS to the proactive approach the geriatric fracture team takes to patient care, including performing the surgery as soon as possible, getting the patients out of bed early in their stay, and gathering information from family members in the emergency department so the care managers and social workers can begin on the discharge plan.

"One key factor in the drop in length of stay is that we focus on performing the surgery within 48 hours, preferably within 24 hours," Balsamo says. "When elderly patients break their hip, they face an additional risk of dying or experiencing complications such as skin breakdown, pneumonia, and deep venous thrombosis if surgery is delayed more than 48 hours."

The program includes orthopedic certified physical therapists that get the patients up and moving as quickly as possible after surgery. All geriatric

EXECUTIVE SUMMARY:
The geriatric fracture team at Geisinger Wyoming Valley Medical Center in Wilkes-Barre, PA, takes a proactive approach to patient care, which has resulted in a decrease in lengths of stay by more than two days.
- The goal is to perform surgery within 48 hours, and preferably within 24 hours.
- Physical therapists certified in geriatric care get patients out of bed as soon as possible.
- Nurses perform a delirium screen on every shift.
- The team compiles as much information as possible in the emergency department so that discharge planning can start on day 1.

patients are seen by pain management specialists who try to control the pain with acetaminophen or low doses of morphine, rather than barbiturates or other medications that can contribute to delirium in the elderly.

Every nursing shift conducts a delirium screen by asking patients to answer simple questions such as what hospital they are in, the day and the month, names of their children, and their own home address. If there is a change in the baseline, the nurse notifies the physician. "Delirium is a major postoperative problem in geriatric patients," Balsamo says. "Physical therapy can't work with patients if they have delirium, and if they're not involved with physical therapy, they are at risk for pneumonia. If patients are on bed rest for several days, it takes a long time for them to recover their muscle tone."

The geriatric fracture care team includes emergency physicians, orthopedic surgeons, hospitalists, anesthesiologists, physician assistants, nurses, physical therapists, and care managers. All team members follow standardized order sets and protocols geared to the special needs of older orthopedic patients. "We have developed a full geriatric program where everybody gets involved in how to treat our patients. The wheel doesn't turn if everybody isn't involved," Balsamo says.

The patients are followed by a nutritionist beginning with the first day of the hospital stay to ensure that they are getting sufficient nutrition to help them avoid pressure ulcers. Every patient is also seen by the blood conservation team. The care managers and social workers ensure that the patients are getting the physical therapy and occupational therapy consultations they need and to start on the discharge plan. If a patient falls or there is a question about whether they hit their head, they are seen by a neurologist.

The team looks at core measures every month to ensure that all the patients are getting the recommended care. The team has been 100% compliant on all orthopedic core measures since the program began. The hospital starts to gather information on potential patients before the fractures occur. The geriatric nurse coordinator for the program visits local nursing homes and gives the staff forms with spaces for healthcare history, phone numbers of family members, the patient's legal guardian, and advanced directives. The staff fills out the forms for each resident and puts them in an envelope supplied by the hospital.

When a patient comes into the hospital, the nursing home sends the envelope, giving the emergency department physicians the information they need to begin treatment. When geriatric patients have fractures, the orthopedic team starts early to engage the family and patient in the recovery process. "Getting the family involved from the beginning cuts down on problems," Balsamo says. "They understand why we get the patient out of the bed quickly and why we are not going to over-sedate the patient."

The team has developed a packet with information on the geriatric fracture program and questions about the patient's living situation, participation in activities of daily living, details about the house layout, the family doctor, and medications.

The geriatric fracture team continues its interventions after the patient is discharged by referring them to Geisinger's High Risk Osteoporosis Clinic for follow-up treatment, such as bone density supplements, and therapy that includes exercises and training to help reduce the risk of future fragility fractures. "Patients with a history of any type of fracture have a two- to sixfold increased risk of subsequent fractures, and that puts them at greater risk for disability," Balsamo says. "Optimal patient care for fragility fractures includes diagnosing and treating the underlying causes of the fracture, and educating the patient and family on how to prevent falls in the future." ■

In-home visits reduce utilization for elderly

Program generates 195% ROI

A program that sends geriatricians and nurse practitioners into the homes of high risk, frail elderly patients has resulted in a 195% return on

investment (ROI) for Fallon Community Health Plan in Worcester, MA.

The Home Run Program began in 2009 after the health plan and Fallon Clinic looked for ways to reduce healthcare utilization for Medicare Advantage members.

"The health plan and the clinic share risk for the care of these patients," says **Patricia Zinkus**, RN, CCM, director of case management. "We focused on the rising medical costs and the increase in the aging population."

Participants in the program might have multiple chronic conditions, including depression and other issues that put them at risk for complications and hospitalizations. Many of the members who are in the program have difficulty getting to their primary care physician regularly or have sought care in the emergency department when acute symptoms have occurred.

"We know that a small percentage of members are responsible for the majority of healthcare costs," Zinkus says. "Our goal is to improve the functional status and quality of life for frail, homebound, or those members with chronic progressive conditions in our Medicare Advantage population and to reduce preventable hospital admissions, readmissions, and emergency room visits."

Members in the program receive monthly in-home visits from a nurse practitioner who assesses their needs; helps them follow their care plan; and arranges for needed healthcare, equipment, and services. A geriatrician from Fallon Clinic visits the members periodically and when the nurse practitioner recommends it.

The health plan used a predictive modeling program to identify Medicare Advantage members at highest risk for healthcare utilization or hospital admissions. The target of the program is 150 members. **Susan Legacy**, RN, senior manager, case management says "It vacillates as some members transition into hospice or other programs. We try to keep it close to 150. "We used a predictive modeling tool after initially utilizing claims data. Because of the lag between the time the members use the services and the time we receive the claim, we missed opportunities to make a difference."

The clinical staff of the Home Run Program reviewed the files of members identified by predictive modeling and referrals from various providers to determine if there were any common denominators that interventions could address. They determined that most of the people identified had experienced a significant functional decline as the result of a fall or an illness. Some had a limited ability to participate in activities of daily living and were not able to get out of the house and socialize at their previous level of function, Legacy says.

The health plan has a contract with a local visiting nurse agency that supplies the nurse practitioners who make the home visits, Zinkus says. "This program does not take the place of the patient's primary care physician," she says. "The health plan, the nurse practitioner, and the geriatrician at the clinic all work in collaboration with the primary care physician."

When a member is identified for the program, the health plan's program support coordinator refers the member to the clinic's geriatrician, who reviews the medical record and determines if the member meets criteria. A letter is sent to eligible members explaining the program and outlining the benefits.

The support coordinator follows up and schedules an appointment for the nurse practitioner to visit the member in the home and conduct a comprehensive assessment. "The nurse practitioner is able to see the home environment and can determine if patients understand their medication regimen or if they need additional teaching," Zinkus says. "They can see safety issues in the home or anything else that can lead to an adverse event."

For example, the nurse practitioner can determine if patients with heart failure have scales to check their weight every day and if their pantry and refrigerator are stocked with high sodium foods. They can help patients make appointments with their primary care provider, arrange for additional home care services, or set up medication reminder systems if needed.

After the initial visit, depending on the needs of the member, the nurse practitioner makes monthly or bi-monthly follow-up visits. The nurses call in a Fallon geriatrician for a home visit when they think it's warranted by the patient's condition.

EXECUTIVE SUMMARY:

Fallon Community Health Plan in Worcester, MA, achieved a 195% return on investment on its Home Run Program that sends geriatricians and nurse practitioners into the homes of high risk, frail elderly patients.

- Participants are identified by predictive modeling and referrals from providers.
- Nurses visit the patients monthly and call in the geriatrician when necessary.
- The program includes a monthly event with speakers, refreshments, and activities.

Program participants can call the Home Run Program or the after-hours line at any time for assistance.

As an adjunct to the home visits, the health plan developed the Home Run Club, a monthly event for participants in the Home Run Program. The events are at Summit Elder Care, a senior center where the health plan operates the PACE (Program for All-Inclusive Care for the Elderly). The health plan arranges for a speaker, refreshments, and fun activities, and it provides transportation for members who need it. Zinkus says, "This is a way for the seniors to get out of the house and interact with peers," she says. "We feel that the socialization piece of the program is crucial to its success."

A social worker from Fallon Community Health Plan runs the program, and it's often attended by members of the health plan's case team. Often the members will ask a question about their health, and this question gives the staff an opportunity to educate the members or suggest that they call their doctors.

Patients may remain in the program until they experience a major life change such as moving into a skilled nursing facility or a hospice, or until they receive care from PACE. Patients whose condition stabilizes to the point that they no longer need home visits are transitioned to telephonic case management. They receive regular outreach calls from the health plan's case managers for at least three months.

"One of the other successes of the program is that we have been able to help people transition to the appropriate level of care," Zinkus says. 'If the members really need hospice care or the nurse practitioner determines that they can't live safely at home, the geriatrician can visit the home and sit down with the family and discuss alternative means of care." ■

CMs follow up by phone after discharge

Transition from hospital to home eased

At Independence Blue Cross in Philadelphia, case managers work closely by telephone with Medicare Advantage members with chronic conditions that put them at risk for rehospitalization, which helps them transition from the hospital to the community and ensures that their needs are met after discharge.

The program, which began in April 2011, is a redesign of the insurer's successful Transitional Case Management Program that provided face-to-face visits to eligible members while they were in the hospital and telephone follow-up after discharge.

"As many of the hospitals in our area began to focus on their own transition-in-care programs, we felt we could better serve our members if we converted to a telephonic model," says **Diana Lehman**, RN, BSN, CHIE, director of case management for Independence Blue Cross.

Members eligible for the program are those with conditions and/or comorbidities that put them at risk for readmissions. These conditions/comorbidities include congestive heart failure, pneumonia, pulmonary diseases, cardiac issues, and renal problems. Members who could benefit from the transitional care program are identified based on their condition as well as being referred when the health plan's utilization review staff determines that a member has complex needs.

Case managers call the eligible patients while they are in the hospital to remind them to review the discharge summary with hospital staff and stress the importance of filling their prescriptions and making a timely follow-up appointment with their primary care physician. They educate the members about their chronic condition and symptoms that indicate they should call their physician.

After discharge, case managers follow the patients an average of 90 to 120 days, depending on the individual's needs. Shortly after discharge, the case manager conducts an in-depth telephone assessment of potential needs and barriers to following the treatment plan. The assessment looks at the member's cognitive and language abilities, functional limitations, the extent to which they are taking medications as prescribed, transportation needs, and end-of-life planning.

The case manager and the member review the discharge plan and medication regimen and work together to develop a plan that will help the member achieve optimal level of wellness. If members are taking duplicate medications or are confused about them, the case managers urge them to contact their physician for clarification. They help the members schedule doctor visits and often work with caregivers to determine members' needs.

"The case managers look holistically at what is going on with the members and, in addition to taking care of discharge issues, link the members with community resources and collaborate with

EXECUTIVE SUMMARY:

Telephonic case managers at Independence Blue Cross in Philadelphia help at-risk members with chronic conditions transition from the hospital to home.

- Case managers make the initial contact when the patient is in the hospital and follow up after discharge, which ensures that they understand their medication regimen and have a follow-up doctor's appointment.
- They conduct an in-depth assessment to identify individual needs and barriers to following the treatment plan.
- They collaborate with health plan social workers, pharmacists, and the behavioral health team to ensure that patients' needs are being met.

our pharmacy and behavioral health divisions to make sure they get the services they need," Lehman says. For example, the case managers collaborate with the pharmacists in finding less expensive alternatives if patients report that they can't afford their medication. Armed with information from the pharmacist, the case manager will facilitate a conversation with the physician and ask if a less costly alternative medication would be effective.

The Medicare case management team and some of the behavioral health team work in the same office, which enables them to co-manage members with depression, anxiety, and other mental health issues. When members need community resources, such as help with transportation to physician visits, the case managers can call on a social worker for assistance. The social work team at Independence Blue Cross works closely with the Philadelphia Corporation for Aging to identify services for members and has a representative on the organization's advisory committee.

If the case manager has any concerns about the member's condition or understanding of the treatment regimen, he or she can contact the home health nurse for more information. For example, the treatment plan for patients with congestive heart failure calls for patients to eat a low-salt diet and to weigh themselves daily. If the Independence Blue Cross case manager has difficulty determining information about the patient's weight gain or diet by telephone, he or she would call the home health nurse and ask for more information. Depending on the situation, the case manager might relay the information to the patient's doctor.

In situations in which home health has not been ordered, if the case manager thinks the patient might benefit from home health visits, he or she will call the patient's physician, explain what is happening and ask for an order. ■

Social media is message for occupational health

Tweets, blogs, and a brave new world

Social media is opening up new avenues for delivering health and safety information. Employee health professionals can download training videos from YouTube, track occupational health news or research on a blog or Twitter, and even communicate with their own employees through social networking sites.

"Social media is a way to connect, it's a marketing tool," says **Max Lum**, EdD, MPA, a consultant in communication and research translation in The Office of the Director at the National Institute for Occupational Safety and Health (NIOSH). "It's just a more efficient way of being transparent and timely, if you manage it correctly."

NIOSH has made savvy use of social media as a way to disseminate its scientific research and recommendations beyond the usual news releases and journal articles. The agency puts out about 10 to 15 tweets per week and has almost 100,000 Twitter followers. Its science blog has had 400,000 views since it started in 2007 and has posted thousands of comments.

You can find NIOSH photos on Flickr, videos on YouTube, and information on Wikipedia. NIOSH also maintains Myspace and Facebook pages. "We're a research organization that puts out a huge amount of information," says Lum, who notes that NIOSH researchers produce 200 to 250 peer-reviewed journal articles each year. Social media provides another way to reach the public and share information, he says.

Growth is slow but steady

The Occupational Safety and Health Administration (OSHA) has made only modest forays into social media. The agency tweets through the Department of Labor account and sometimes issues videos on YouTube. OSHA administrator **David Michael**s, MD, MPH, and other OSHA officials have answered questions via live web chats.

Some individuals focused on occupational health and safety also maintain Twitter accounts or blogs. For example, **Brad Hammock**, JD, an attorney with Jackson Lewis in Reston, VA, specializes in occupational health law and maintains a blog and Twitter account. Hammock tries to stick to factual updates and doesn't offer legal opinions on his blog. He has noticed that his posts and tweets are picked up and linked or re-tweeted.

"It creates a loop of information-sharing that you didn't have five years ago," he says. "It's such an effective way to transmit information."

Beyond the generation gap

The main barrier to social media simply might be discomfort with a new way of communicating. After all, aren't tweets just for celebrities? Or teenagers?

Lum didn't take it too seriously at first when his sons were on blogs or YouTube or Facebook. But then he attended a meeting of the American Marketing Association and learned that marketing professionals were using social media to reach out to a new generation of consumers.

Each type of social media has its benefits. Tweets are short bursts of information, but they can link to web sites, which is an ideal way to spread the word about a conference or workshop. Blogs allow readers to scroll through everyone's comments.

Lum, who was previously the director of the NIOSH Office of Communications, saw the potential for open government through these tools. "It really started with an idea to see if we could get more transparency and reach a larger audience," he says.

Now, NIOSH is exploring creating an "app"—a smartphone application — that would help people select the right respirator. "When I get that first app out, I think it will be really impressive to my children," says Lum. ■

Money talks: Cold cash and other incentives

A way to launch, but worker must finish

It might seem like a "no-brainer" to you, but it's not always enough to simply ask workers to make changes for better health. You might need to offer other incentives to get them to take action, 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.

"Many companies are using incentives to encourage healthy behaviors," says Weiss. "They are trying to control health care costs by encouraging healthy lifestyles."

Research from HCMS Group, a health IT and clinical services company based in Cheyenne, WY, has shown that investments in wellness have a higher likelihood of making a difference when other business practices already are aligned with wellness, says **Nathan Kleinman**, PhD, director of research services at HCMS. For example, a wellness or safety incentive might have less of an impact at a company at which employees have little or no opportunity to earn more for working harder.

"On the other hand, if employees can earn salary bonuses for improved performance, they are more likely to view maintaining good health as important," Kleinman says.

Incentives for participation in wellness activities and challenges range from prizes to money to significant decreases in healthcare premiums, says Weiss. "Companies usually move through a continuum of options," she says.

Initially, companies usually start with providing incentives for participation in wellness-related activities. Other financial incentives are based purely on utilization, such as co-pays for emergency department care versus outpatient or clinic care, Weiss says. Once companies initiate a health risk assessment, premium costs may be linked to employee participation, then spouse participation.

"The third step is to integrate biometrics in the equation," Weiss says. "These strategies have proven effective in minimizing health care cost premium increases."

Changing it up

Tracey L. Yap, RN, PhD, an assistant professor at the College of Nursing at University of Cincinnati (OH), says that an occupational health professional might use incentives as a way to "get people to launch," but Yap says you need to get creative after that.

"You can't do the same thing all the time, with repetitive stuff. You need to change it

up," she says. "That takes a lot of upfront work and energy." Here are Yap's recommendations for use of incentives:

• Consider the "stage" of the person.

When Yap held focus groups with employees at manufacturing plants, she learned that individuals in the "preparation" stage of change really didn't care about the incentives being offered as much as they did about competition. "For them, it really was about gaming against their fellow workers in other plants," she says.

In that same study, incentives combined with health behavior change education moved employees that were in the "pre-contemplation" stage of change to the "action" stage, says Yap. "The incentive can get some people rolling. It can probably push somebody to get started, but obviously incentives are not a sustainable way for behavior change," she says.

• Ask what they want.

If you're wondering what would really jump-start an employee to make a lifestyle change, just ask him or her, says Yap.

"Always go to them first. Ask what would get them engaged," she says.

Yap once offered Starbucks gift cards to get employees at a manufacturing plant to complete a questionnaire, but she later learned the closest location for Starbucks was 45 minutes away. Later, those employees told her they would rather have had Wal-Mart gift cards, but supermarket gift cards are another practical choice, says Yap.

To learn this in advance instead of after the fact, Yap says to "just randomly grab a few people and ask them what would get them engaged. Always personalize whatever you do."

• Give the equivalent of at least an hour's pay.

While the amount of incentive needed "depends on the crowd," a good ballpark figure is at least an hour's pay, Yap says. "Depending on what you are doing, being too cheap may be considered insulting," she says.

• Offer a variety.

If you're offering items such as duffle bags, water bottles, or T-shirts, provide a variety of choices, says Yap. "Do people really want a T-shirt with the company logo on it? People know you bought them in bulk, and they don't feel important," she says. "I think a lot of people want gift cards, especially around holiday time."

SOURCES

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Peer counselors double breastfeeding rates

To improve breastfeeding initiation and its continued practice, administrators at the Prentice Ambulatory Care (PAC) Clinic of Northwestern Memorial Hospital in Chicago set in place a peer counseling program. Their efforts boosted the rate of women initiating breastfeeding to 84%, from 40%. *(See more statistics, p. 94.)*

"Their goal was to place a peer counselor in the clinic to provide education and support during pregnancy and up to a year postpartum to improve the rates of breastfeeding initiation, exclusivity, and duration," explains **Pam Chay**, RN, IBCLC, patient care coordinator for Multiple Births and Education at Northwestern Memorial Hospital.

PAC provides outpatient women's services, including obstetrics and gynecological care, to about 500 patients a year within the Chicago community. Many of these patients are underinsured or uninsured. "The breastfeeding rates in the clinic were quite a bit lower than our private insured patients. The data showed there was about 40% initiation of breastfeeding for the patients at PAC, compared to 85% for our private insured patients, so that is why the program was implemented," says Chay.

Money was given to fund the project in 2008 by The Evergreen Invitational Grand Prix Women's Health Grant Initiative. The program was ready to launch in 2009, and it continues to receive funding through this grant. The grant is called "Partnership to Improve Breastfeeding Rates Using Peer Counselor Education and Support."

Providing personal attention

The peer counselor, who is paid through grant monies, meets one-on-one with patients to discuss the benefits of breastfeeding, answer questions, and dispel myths. She meets with patients a sec-

ond time during a clinic visit, whether or not they are intending to breastfeed their baby, just to see if they have anymore questions, says Chay.

Also she instructs a prenatal breastfeeding class for clinic patients once a month. It is two hours long and consists of lecture, discussion, demonstration, and a short video-clip on breastfeeding. The class is free and includes a catered lunch for the families attending. Couples also receive a book by Amy Spengler titled "Breastfeeding: A Parents Guide." They are also given a DVD called "Breastfeeding Intensive" by Mother of 7 at no cost to them.

The peer counselor puts patients who have a high desire to breastfeed on her caseload and usually has about 30, says Chay. These are the women she talks to after delivery while they are in the hospital. If they are having difficulty breastfeeding, she makes sure they get help from the nurses and, if needed, from a board-certified lactation consultant.

Once the mother and baby are discharged, the peer counselor calls to provide support and guidance. The patient has the counselor's number as well. The peer counselor calls at least every three weeks and meets with the mother at her six-week postpartum visit at the clinic. If she still is breastfeeding exclusively at the time of the clinic visit, an incentive package is given that includes a T-shirt for baby, a camisole for mom, and a baby sling. "Even the patients who are not on her caseload have her phone number, so if they have any questions or issues they can call her," says Chay.

To be a peer counselor for PAC, a woman must have successfully breastfed her baby exclusively for at least four months and have been a patient of the federally funded Women, Infants, and Children (WIC) health and nutrition program. Also she undergoes 20 hours of training through HealthConnect One. This Chicago-based nonprofit agency offers training and technical assistance to service providers promoting the health of mothers, infants, and families.

SOURCE/RESOURCES

For more information about creating a peer counselor program, contact:

• **Pam Chay**, RN, IBCLC, Patient Care Coordinator, Multiple Births and Education, Northwestern Memorial Hospital, Chicago, IL. E-mail: pchay@nmh.org.

• ***Breastfeeding: A Parent's Guide*** by Amy Spangler is available at her web site Babygooroo. Web address: www.babygooroo.com. Click on "store" and scroll down to the book title. The book costs $12.50 plus shipping and handling for one copy, with discounts for bulk orders.
• ***Breastfeeding Intensive*** produced by Mother of 7 available at www.motherof7.com for $57 plus shipping and handling. ■

Data supports peer counseling

Breastfeeding is on the rise

The data on the Breastfeeding Peer Counselor program and free breastfeeding classes for mothers receiving care in the Prentice Ambulatory Care Clinic in Chicago show it is successful.

From January 2009 to December 2010, the breastfeeding peer counselor has done the following:

• Counseled 861 women.
— 84% initiated breastfeeding; compared to 40% previously.
— 40% breastfed exclusively in the hospital.
• Conducted a total of 230 hospital visits with mothers in the postpartum unit.
• Provided 20 breast pumps for mothers that are separated from their babies.
• Taught a total of 23 breastfeeding classes; 340 people have attended a class.
• Enrolled 71 women were enrolled in a more intensively supported caseload.
— 94% initiated breastfeeding;
— 51% breastfed exclusively at the hospital; compared to 14% previously.
— 70% continued to breastfeed at six weeks; compared to 17% previously.
— 52% continued to breastfeed at three months;
— 36% continued to breastfeed at six months;
— 9% continued to breastfeed at 12 months.

Injured workers should not return too soon

There might be pressure to return an injured employee to work as soon as possible by management, human resources, or supervisors. However, returning someone to work too soon can put the employee at risk, warns **Mary D.C. Garison**, RN, COHN-S, CCM, COHC, FAAOHN, an Angleton, TX-based occupational health nurse.

There is the potential for re-injury or aggravation to a worker's pre-existing condition. "This can turn out to be workers' comp, even if it is a non-occupational injury or illness," Garison adds.

Here are some suggested steps from Garison for occupational health managers to take if they feel pressured to return an employee to work sooner than they think is appropriate:

- Have the attending physician to support with a letter stating the employee's need to stay out until healing is complete.
- Request a return to work physical performance evaluation, and provide the physician with an analysis of the physical demands of the employee's job.
- Remember that the occupational health manager is the employee's advocate.

Litigation possible

Small employers are often "frantic" about not reporting a legitimate injury to their worker's compensation insurance company, according to **Judy Van Houten**, director of the Glendale (CA) Adventist Occupational Medicine Center.

"They pressure the occupational health professional to delay treatment, minimize services, and return employees to their 'usual and customary' position far too early," she says.

Months may go by with the injury still remaining unresolved, Van Houten says. "Then, they become angry when the injured worker litigates," she says. "There are no easy answers as to how to resolve this phenomenon, especially in this economy."

Small employers are often the biggest deterrent to the occupational health process, because of lack of education and economic pressures, she notes. "The biggest challenge is educating them about what is, and is not, a first-aid claim," Van Houten says.

The best approach is for the occupational health manager to persuade the employer to provide the injured worker with the treatment and benefits that they are entitled to, she emphasizes. The occupational health manager can reinforce the legal ramifications of not doing so, Van Houten says. "This is a tough position for the occ health professional at best."

Act as translator

Communication might be the single most important factor with managing worker's compensation cases.

"The occupational health nurse is, by far, the most instrumental person who can facilitate this," Van Houten says.

Supervisors or employees might use language to describe tasks that is unfamiliar to occupational health professionals. The occupational health manager should translate this information into language that the primary care provider can better understand, Van Houten says. This "translation" is the key to developing work restrictions or defining modified duty assignments for an injured worker, says Van Houten.

There are many parties involved in the management of a workers' compensation claim, she says. The occupational health professional is "the key

COMING IN FUTURE MONTHS

- What you should know about culturally competent care
- New opportunities opening up for case managers
- How medical homes improve outcomes for chronically ill
- Projects that aim to reduce hospital readmissions

to balancing the different needs of the parties, to ensure prompt treatment, prompt recovery, and prompt return to work," Van Housten says.

SOURCES

For more information on returning an injured employee to work safely, contact:

• **Mary D.C. Garison**, RN, COHN-S, CCM, COHC, FAAOHN, Angleton, TX. E-mail: marygarison@sbcglobal.net.
• **Judy Van Houten**, Director, Glendale (CA) Adventist Occupational Medicine Center. Phone: (818) 502-2050. E-mail: VanHouJA@ah.org. ■

CNE QUESTIONS

5. According to Moreen Donahue, DNP, RN, chief nurse executive and senior vice president of patient care services at Danbury (CT) Hospital, the process of care for elderly patients is different from the process of care for younger patients.
   A. True
   B. False

6. According to Anthony J. Balsamo, MD, orthopedic surgeon at Geisinger Wyoming Valley Medical Center, geriatric fracture patients have an additional risk of dying and experience more complication if surgery is not performed within what timeframe?
   A. 24 hours
   B. 48 hours
   C. 72 hours
   D. 84 hours

7. How often do patients in Fallon Community Health Plan's Home Run program receive an in-home visit from a case manager?
   A. Weekly
   B. Bi-Weekly
   C. Monthly
   D. Bi-Monthly

8. Peer counselors at Prentice Ambulatory Care (PAC) Clinic of Northwestern Memorial Hospital provide education and support to women during pregnancy and post-partum with the goal of improving the rates of breastfeeding. What is the usual caseload for a peer counselor?
   A. 30
   B. 25
   C. 35
   D. 20

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 and earn credit for this activity by following these instructions.
1. Read and study the activity, using the provided references for further research.
2. Log on to www.cmecity.com to take a post-test; tests can be taken after each issue or collectively at the end of the semester. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■