CASE MANAGEMENT ADVISOR™

COVERING CASE MANAGEMENT ACROSS THE ENTIRE CARE CONTINUUM

NOVEMBER 2014 Vol. 25, No. 11; p. 121-132

INSIDE

AHC Media

Primary care practices are the latest opportunity for CMs

Chronically ill, frequent utilizers are the target

New opportunities are opening up for case managers in primary care as physician practices, healthcare systems, and health plans recognize the value of care coordination.

Primary care practices, especially large physician practices and community clinics, are looking at integrating RN case managers and social workers into their practices, says **Cheri Lattimer**, RN, BSN, executive director of the Case Management Society of America (CMSA).

"Physicians are recognizing that case managers can take the role of advocate, improve care coordination and communication, and support the patient as they move through the continuum of care," she says.

Primary care offers a great opportunity for case managers to work with patients and their family caregivers and help them gain the skills to manage their healthcare resources and be self-sufficient, she adds.

> "THERE IS DEFINITELY A ROLE FOR CASE MANAGERS IN PRIMARY CARE TO MANAGE THE SICKEST OF THE SICK..."

"There is definitely a role for case managers in primary care to manage the sickest of the sick and do targeted population management," says **Mary Morin**, RN, NEA-BC, RN-BC, nurse executive with Sentara Medical Group, a division of Sentara Healthcare System, which operates throughout Virginia and northeastern North Carolina.

Sentara Healthcare System redesigned its primary care case management program and now has

Financial Disclosure: Editor **Mary Booth Thomas**, Associate Managing Editor **Jill Drachenberg**, Executive Editor **Russ Underwood**, and Nurse Planner **Margaret Leonard** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

CASE MANAGEMENT ADVISOR™

Case Management Advisor™,
ISSN 1053-5500, is published monthly by
AHC Media, LLC
One Atlanta Plaza
950 East Paces Ferry Road NE, Suite 2850
Atlanta, GA 30326.
Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to:
Case Management Advisor
P.O. Box 550669
Atlanta, GA 30355.

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421.
customerservice@ahcmedia.com.
www.ahcmedia.com
Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

EDITORIAL E-MAIL ADDRESS:
marybootht@aol.com.

SUBSCRIPTION PRICES:
Print: U.S.A., Print: 1 year (12 issues) with free Nursing Contact Hours or CMCC clock hours, $419. Add $19.99 for shipping & handling. Online only, single user: 1 year with free Nursing Contact Hours or CMCC clock hours, $369. Outside U.S., add $30 per year, total prepaid in U.S. funds.

MULTIPLE COPIES: Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482.

Back issues: $75. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date.
GST Registration Number: R128870672.

ACCREDITATION: AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. This activity has been approved for 15 nursing contact hours using a 60-minute contact hour. Provider approved by the California Board of Registered Nursing, Provider # 14749, for 15 Contact Hours.

This activity has been approved by the Commission for Case Manager Certification for 18 clock hours. This activity is valid 24 months from the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

EDITOR: Mary Booth Thomas (770) 939-8738, (marybootht@aol.com)
ASSOCIATE MANAGING EDITOR: Jill Drachenberg (404) 262-5508
EXECUTIVE EDITOR: Russ Underwood (404) 262-5521, (russ.underwood@ahcmedia.com)
EDITORIAL & CONTINUING EDUCATION DIRECTOR: Lee Landenberger

embedded case managers in 38 primary care practices. The case managers have an office in each practice to which they are assigned and schedule their time at each practice. In the first three years, the total cost of care dropped by 17% over a three-year period and all-cause readmissions dropped by 21% for patients in the program. *(For details, see related article on page 123.)*

The number of case managers in primary care practices is on the increase as healthcare systems and insurance companies embed case managers in the practices to identify and coordinate care for patients who are frequent utilizers of the healthcare system, says **Catherine M. Mullahy**, RN, BSN, CCRN, CCM, president and founder of Mullahy and Associates, a Huntington, NY-based case management consulting firm.

There are a lot of benefits in having a case manager in a physician practice, especially if the practice is part of an accountable care organization, Mullahy says. "If there is a set number of dollars to manage everybody and some patients are using the bulk of the resources, it make sense to have someone who can work with those patients to help them learn to manage their own healthcare," Mullahy says.

Case managers in primary care are the physician's partner, Mullahy says. "They have the ability and skill to take the time needed to talk with patients and family members. They have the clinical expertise and skills to work with people," she says.

Care coordinators provide a pivot point between the patient, the health plan, and the physicians and nurses in the primary care practices that are part of Cigna's collaborative accountable care initiative, says **Harriet Wallsh**, RN, director of Cigna collaborative care clinical operations in Orlando, FL. The care coordinators in the physician practices are employed by the practices and work closely with Cigna case managers to make sure patients get the services they need, she adds.

"Care coordinators are an important component in meeting our goals of improving quality, affordability, and the experience of care," she says. *(For details of how the care coordination process works at one practice aligned with Cigna, see related article on page 125.)*

Population care coordinators are a key part of Horizon Blue Cross

EXECUTIVE SUMMARY

Recognizing that there are patients who need a lot of support in managing their conditions and optimizing their health, healthcare systems and health plans are embedding case managers in primary care practices.

- Case managers in primary care have the time and expertise to educate patients about their conditions and support them in following their treatment plans.
- Organizations with case managers on staff report an increase in preventive care and lower healthcare costs for patients who work with the case manager.
- Case managers have the satisfaction of developing relationships with patients and seeing patients progress over time.

Blue Shield of New Jersey's patient-centered physician practice initiative, according to **Steven Peskin**, MD, MBA, FACHE, senior medical director, clinical innovations for Horizon Blue Cross Blue Shield of New Jersey.

The population care coordinators focus on the top 5% to 10% of patients who are sickest but who potentially can control their conditions. They work at the individual practices and meet patients in person as well as corresponding via telephone, email, and text messages.

(For details, see related article on page 126.)

When case managers work in primary care practices, it's a win-win-win situation, Mullahy adds.

The patients get the help they need in managing their conditions and maximizing their health. Physicians have someone on their staff who has the time and expertise to give patients the support they need to follow their treatment plan, and case managers benefit because they can do what they went into nursing to do — make a difference in people's lives, she adds.

Unlike hospital-based case managers who see their patients in the hospital and lose touch when patients are discharged, case managers in primary care develop long-term relationships with patients, Mullahy points out.

"Case managers in primary care are managing a small group of people who really need their help. The case managers are able to experience what most of us envisioned case management to be. They provide a relationship-based model of care and really make a difference," she says. ■

Embedded CMs reduce readmissions, increase follow-up, cut costs

High-cost, high-utilizing patients are targeted

After Sentara Healthcare System's embedded case management program was redesigned, the total cost of care for patients in the program dropped by 17% over a three-year period.

All-cause readmissions were reduced by 21% for patients in the program. There was a 23% increase in advance care plans and a 77% increase in seven-day follow-up appointments. When the program started, only 21% to 30% of patients saw their physician within seven days after discharge. Now, the rate is typically in the high 80% range, and has been as high as 98%, according to **Mary Morin**, RN, NEA-BC, RN-BC, nurse executive with Sentara Medical Group, a division of Sentara Healthcare System, which operates throughout Virginia and northeastern North Carolina.

Before Morin joined the medical group in 2011, the health system had two embedded case managers in two medical practices and two telephonic case managers who worked in the corporate office. The program targeted heart failure patients in two primary care practices and those who were indigent or self-pay and who had received care at two hospitals. "The nurses were spending 75% of their time functioning as an office nurse bringing in patients or acting as a personal nurse to a physician," Morin said.

As part of the redesign, Morin and her team developed all new job descriptions and set out expectations for the case managers. The program uses only bachelor's-prepared nurses who have at least three years of acute care or ambulatory nursing care experience. If they are not already certified, they must sit for certification within a year of eligibility.

The redesign of the program removed the case managers from the physician offices and corporate offices and expanded the focus to 11 practices. Now patients from all payers, including Medicare and Sentara Health Plan, are eligible for the program. The program has expanded to 38 primary care practices.

The case managers are assigned to physician practices and schedule their time at each practice. They have an office in each practice to which they are assigned, and are part of the care team in each practice. They are equipped with smartphones and laptops.

The case managers were told their jobs would change when the program was revamped, but they didn't realize all that was involved, Morin says.

"I had 100% turnover within a year and 75% turnover in six months. In retrospect, I should have made them reapply for the job," she says.

The case managers received education on motivational interviewing, engaging patients and

family members, understanding and managing chronic disease, pharmacology, family dynamics, and community resources.

Sentara developed a computer platform allowing the case managers to keep their schedule up to date and track data on their patients.

Morin and her team focused on patients who were identified as high-cost, high-utilizer patients, except for patients with cancer, trauma, and other catastrophic illnesses. The remaining patients had renal failure, heart failure, diabetes, chronic obstructive pulmonary disease, chronic pain, and behavioral health issues. The majority of patients in the program range in age from the 30s to the early 60s.

About 2,400 patients who met all the criteria were patients at the 11 participating practices. The team asked the physicians to identify those who would most benefit from interventions. The goal is for the case managers to have an average caseload of around 150 patients, she says.

When the program began, Sentara sent out letters to the targeted patients and the case managers contacted them by telephone and saw them in the hospital whenever possible, Morin says.

"We got 100% engagement from patients we visited in the hospital and only 80% engagement when we sent letters. People are eager to participate when they're in the hospital," she says.

Once the patients agree to join the program, the case manager makes a visit to the home or sees the patient during an office visit to make an initial assessment, facilitate the patient in developing an advance care plan, and develop a care plan based on any needs the patient might have. The case managers set up a routine touch point with patients. They call or see some weekly, others quarterly, and some every day, Morin says.

The case managers are able to see through the electronic medical record the list of patients coming into each practice and, based on this, they develop a schedule, she says. Their goal is to see patients face to face when they have a physician visit.

Case managers are alerted when patients are admitted to the hospital and visit them whenever possible.

The case managers call the frequent emergency department users to check on them. They may make home visits if they feel the patient needs extra support. The care managers follow all medical patients who are discharged from the hospital for at least 30 days as part of the medical group's intense transition process to reduce unnecessary emergency department visits and hospital readmissions. Some of these patients will become long-term care management patients if they have complex diseases or conditions, Morin says.

"The case managers engage the patients and manage their care through home visits, hospital visits, group visits, and virtual visits with Skype. Patients see the case managers as an extension of their physician, and someone they can call on when they have questions and concerns. Seeing patients in the hospital and going into the home to meet patients on their own turf has paid off greatly," she says.

The physicians in the program have worked with Morin and her team to create an insulin protocol and a furosemide protocol that the nurses can implement, helping the patient avoid an emergency department visit. "The case managers have developed a relationship with the patients who call them when they have symptoms rather than going to the emergency department," she says.

When the program started, the case managers and physicians had a 10-minute huddle every two weeks. "Now the case managers and physicians talk all the time. The physicians see the case managers as someone who is working with them and watching out for them. They've realized how many times they aren't getting interrupted," she says.

One case manager convinced a skeptical physician of the value of the program by working with a patient who was going to the emergency department once a week. That was two and a half years ago and the patient hasn't been back to the emergency department, Morin says. ■

EXECUTIVE SUMMARY

Patients in Sentara Medical Group whose care was coordinated by embedded case managers showed a 17% reduction in cost of care and a 21% reduction in all-cause readmissions.

- Case managers are assigned to physician practices and schedule their time at each practice.
- They visit patients at their home or see them during an office visit and develop a care plan based on the patients' needs.
- They follow up at regular intervals through home visits, hospital visits, group visits, and virtual visits with video chat.

Care coordinators help close gaps in care, lower costs

Gaps in care, chronic conditions targeted

An initiative that included hiring an RN care coordinator to work with patients who needed a higher level of care, or had gaps in care, resulted in significant improvements in preventive care exams, lower costs for hospitalizations, and a decrease in emergency department visits for patients in the program at Jackson Clinic, a multispecialty practice with 136 providers in western Tennessee.

The results are from Jackson Clinic's first year of participation in Cigna's collaborative accountable care initiative, which rewards participants for achieving the "triple aim" of improved health, affordability, and patient experience.

During calendar year 2012, the first year of the program, Jackson Clinic outperformed the market in Cigna quality of care measures, according to **Renee McLaughlin**, MD, Cigna's senior medical director for Tennessee. For instance, the clinic performed 19% better than its peers for annual eye exams and 25% better for annual screenings for kidney disease for people with diabetes, and 50% better than the market for adolescent well care visits.

"A key to the success was having a care coordinator who was working in the organization and helped close gaps in care. We were early adopters of the electronic medical record, and the information we have in those records, plus information from Cigna's claims data, helped us target the patients who needed an intervention from the care coordinator," says **Keith Williams**, MD, FACOG, chief medical officer for Jackson Clinic.

About four years ago, the physician-owned organization began preparing for the shift in healthcare from fee-for-service to fee-for-value, Williams adds. "We knew that if we wanted to provide high-quality care at a low cost, we needed a partner. When Cigna approached us with its collaborative accountable care model, we partnered with them," he says.

Cigna offered the clinic a proposal to continue fee-for-service reimbursement, and also to share any savings in the cost of care.

In the first year, the practice hired an RN care coordinator whose salary was covered by Cigna's care coordination fee. After the first year showed significant savings in closing the gaps in care, the practice added 1.5 FTE RN care coordinators and is developing multidisciplinary physician-directed care teams that include RN care coordinators, nurse practitioners, and LPN medical assistants, he says.

The teams educate patients with multiple conditions on how to take better care of themselves and follow up with patients who have had hospital admissions, Williams says.

"The goal is to drive quality up and costs down while helping patients take their medication as directed, follow their treatment plan, and see their primary care provider regularly so they avoid emergency department visits and hospitalization," he says.

When a patient is identified for the program, the care coordinator researches the medical record to determine if there are gaps in care or any pattern of emergency department use or hospitalizations that indicate disconnected or costly care, he says. They call the patients, educate them on their conditions and medication regimen, and make the primary care physicians aware of any issues their patients are having that may necessitate modifications on the clinical side.

EXECUTIVE SUMMARY

After Jackson Clinic hired an RN care coordinator as part of its participation in Cigna's collaborative accountable care initiative, patients in the program had better preventive care, a decrease in emergency department visits, and lower costs for hospitalizations.

- When patients are identified for the program, the care coordinator determines if there are gaps in care or patterns of healthcare utilization that indicate disconnected or costly care.
- The care coordinator calls the patients, educates them on their conditions and medication regimen, and reports the results of the call to the primary care physician.
- The care coordinator works closely with Cigna case managers and has a standing appointment to discuss particular cases and the patients' needs.

"Identifying and closing gaps in care is still critical, but where that once was the main focus, now our focus is developing the care team to provide coordinated care for patients," Williams says.

Using a computer platform provided by Cigna, the care coordinators can access information in the insurer's database to give them information about patients who need interventions, says **Sarah Johnson**, MHA/INF, RN, director of the clinic's clinical informatics and population health management department. For instance, a care coordinator can select the daily inpatient census list and call patients after discharge to schedule a follow-up visit with their primary care provider within seven days.

"Whenever the care coordinators pull up a registry, they see information about the whole patient," Johnson says. For example, if the care coordinators access information on breast cancer screenings, they can see all of a patient's disease processes, other gaps in care, and whether they are receiving case management from a Cigna care coordinator.

The care coordinators at Jackson Clinic are aligned with specific case managers at Cigna and have standing appointments to discuss particular cases and what interventions they need, says **Harriet Wallsh**, RN, director of Cigna collaborative care clinical operations.

If the case managers in the practice need information or want to refer a patient to a Cigna program, they know they will always get the same case manager, Wallsh says.

The nurses embedded in primary care practices also are supported by a team of field nurses who meet with them face to face, Wallsh says.

"We see ourselves as an extension of the practices, so we work closely with collaborative partners to make sure our customers get the services they need to stay healthy and to optimize health outcomes," she says. ■

Patient-centered care cuts ED visits, admissions

Care coordinators are a key factor

Horizon Blue Cross Blue Shield of New Jersey members who received care at patient-centered physician practices were able to avoid more than 1,200 emergency department visits and 260 inpatient admissions, which represents a savings of approximately $4.5 million, according to **Carl Rathjen**, the health plan's manager of network strategy and program development.

The members had a higher rate of diabetes control and cholesterol management, and a lower rate of emergency department visits and hospital admissions compared to members receiving care in traditional primary care practices, a 2013 internal study showed. Outcomes for the 200,000 patients in the patient-centered medical home included a 14% higher rate in improved diabetes control, a 12% higher rate in cholesterol management, an 8% higher rate in breast cancer screenings, and a 6% higher rate in colorectal cancer screenings.

A key component of the program is population care coordinators, which are nurses who work at participating practices and help at-risk members navigate the healthcare system and manage their conditions,

> A KEY FOCUS IS IDENTIFYING GAPS IN CARE AND ENSURING THAT MEMBERS RECEIVE THE RECOMMENDED TESTS...

says **Steven Peskin**, MD, MBA, FACHE, senior medical director, clinical innovations, for Horizon Blue Cross Blue Shield of New Jersey.

The health plan is collaborating with patient-centered practices in more than 900 locations throughout New Jersey. Small practices may share a population care coordinator. Larger practices may have as many as a dozen. The nurses work at the individual practices and meet patients in person as well as corresponding by telephone, email, and text messages.

Members are identified for interventions by health plan data as well as referrals from members of the practice treatment teams. The individual practices take the data from the health plan to help risk-stratify the patient population, Rathjen says.

"We're not prescriptive about who is on the list for outreach. We provide a list of people who are likely to need interventions, but the providers know their patients and may add other individuals," Peskin says.

"All Horizon Blue Cross Blue Shield members being treated by the practice are eligible for the program whether they are the young or the frail elderly or anyone in between. They may not need services, but when they do, the population care coordinator and the rest of the team are there for them," Peskin says.

The population care coordinators focus on the top 5% to 10% of patients who are sickest, but who potentially can control their conditions if they become engaged in managing their healthcare, he adds. The patients targeted may have multiple comorbidities, medication issues, or have chronic conditions like diabetes or be undergoing treatment for a serious illness like cancer, he says.

The population care coordinators contact any member who has been hospitalized or visited the emergency department to make sure he or she gets a follow-up appointment within 72 hours of discharge if necessary, he says. They develop care plans for members who are at risk and make sure they get the help they need to keep their conditions under control.

"The population care coordinators also reach out to patients who have been going to the emergency department repeatedly. Sometimes that may be a warning sign of an underlying condition," he says.

A key focus is identifying gaps in care and ensuring that members receive the recommended tests and procedures, such as diabetic foot exams and mammograms. "This new model strengthens and builds trust between the physician and the care team and the individual patients. If patients identify the person calling to remind them of a recommended test as being from their doctor's office, there is a better chance they'll follow through than if the call came from a health plan," Peskin says.

The health plan encourages practices to provide team-based care, and has prepared a playbook that helps the practice ensure that everyone performs at the top of his or her license and that everyone on the staff works together as a team.

"Better care is delivered if all persons working in a practice have a sense of being part of a team," he says.

For instance, before a patient comes for an appointment, the care coordinator may tell the physician about a concern the patient mentioned during a phone conversation.

To develop the program, the health plan worked with a physician advisory board of seven family practice physicians and one internist who collaborated on the key elements of the program and continue to give feedback, Peskin says.

With the help of the physician advisory board, the health plan developed a sample job description for the population care coordinators. The care coordinators are hired by the practices and undergo a two-day training session developed by Horizon Blue Cross Blue Shield of New Jersey. The health plan hosts quarterly meetings at two different locations where the care coordinators can share best practices and brainstorm with their peers on challenging patients, he says.

The health plan also launched a pediatric program in January 2014 with a major focus on preventive services, immunizations, and developmental screening.

Horizon Blue Cross Blue Shield of New Jersey rewards practices for improving the patient experience and improving patient care, Rathjen says. "We also provide up-front support to help transform the offices and to hire the care coordinators," he says. ■

EXECUTIVE SUMMARY

Horizon Blue Cross Blue Shield of New Jersey members who received care at patient-centered physician practices had fewer emergency department visits and inpatient admissions, and a higher rate of diabetes control and cholesterol management than patients receiving care at traditional primary care practices.

- Population care coordinators who work at the patient-centered practices help at-risk members navigate the health system and manage their conditions.
- The population care coordinators focus on the top 5% to 10% of patients who are sickest, but who potentially can control their conditions.
- They focus on patients with gaps in care and those who have multiple emergency department visits.

Send us your thoughts

This issue is the debut of *Case Management Advisor*'s new look.

Drop a line and let us know what you think of the new the three-column format, questions box, or any other thoughts you may have.

Send your comments to jill.drachenberg@ahcmedia.com.

Program connects frequent ED users with medical homes, resources

ED-based care coordinators facilitate access, coverage

The ED at Sinai Hospital of Baltimore sees a fair number of patients who frequent the facility for primary care, mental health needs, and other services that emergency providers are not ideally suited to provide. It's a common problem in many EDs, but earlier this year, administrators at Sinai Hospital decided to investigate whether they could devise an intervention that would better meet the long-term needs of these frequent users while also preserving the ED's acute-care resources for patients who really need that level of care.

"We took a look through our own information system to see how many people visited the ED repeatedly," says **William Jaquis**, MD, FACEP, the chief of emergency medicine at Sinai Hospital. "We decided to target a certain group of patients who were frequent utilizers of our services and just see what their needs were and why they were using us in the department."

The investigators concluded that many of the frequent ED utilizers had problems the ED could not adequately address, and that these patients really needed to be connected with other resources. However, making these linkages would require funding and a unique approach. Consequently, the hospital secured a first-year $200,000 grant from the Maryland Community Health Resources Commission, an amount that will grow to $800,000 over three years. Further, the hospital partnered with HealthCare Access Maryland, a non-profit in the state, to pilot a new intervention dubbed the Access Health Program.

Identify prospects

At the heart of the program are three care coordinators from HealthCare Access Maryland who are stationed in the ED over staggered shifts, so at least one of them is usually on hand to intervene with patients who meet the program's criteria for inclusion: They have visited the ED for primary or specialty care four times in four months, and they have needs that the program can help with. "We have created a flag that basically notifies us that a person has been here recently, and it lets us dig a little bit deeper into the patient," says Jaquis. "The care coordinators can see the information as well, and we can also notify them to let them know that this is a person who we feel could benefit from their services."

Nakia Abrams, MS, one of the ED-based care coordinators, says she typically receives referrals from the ED's care management coordinator, a social worker, or an emergency provider. "We are considered contractors with the hospital staff, and as contractors, we have access to the medical record database, so when a client is referred to us, we actually know the reason why he or she came into the ED, and we know their history," she explains. "We can look at all of that information before we visit with them, and we can use it when we go to actually have a discussion with them about the types of programs or services we can probably help them with."

Abrams tries to meet with the patients before they leave the triage area so that she can give them a little bit of information about the program. "We don't dig into it too much at that point because we know that they are there because they don't feel well or they are in pain," she explains. "But we ask them if they are interested [in participating], and if they are, then they sign an agreement indicating that they agree to disclose their information and to follow up with us."

Within a week of enrolling in the program, the care coordinator will schedule a home visit with the patient to conduct a complete assessment and devise a care plan that focuses on patient goals. "The purpose of the home visit is to identify any wrap-around services that we may need to include," says Abrams. "For instance, if there is a situation where we see that the reason why a client continues to come to the ED is because there are things at home that cause an unhealthy environment, then we address that in the care plan."

Abrams notes that she will discuss with patients how she will work with them to accomplish the stated goals in the care plan, what the various required steps will be, and what kind of time frame they can anticipate. What is also made clear is that the patients will only be part of the Access Health Program for 90 days.

"Our program is short-term because the purpose is to connect the client with a longer-term resource," says Abrams. "We want to gain that

client's trust so that we can get all of the information we need to make that connection."

Within the three-month period, however, clients are encouraged to contact their care coordinators with any questions or concerns. "That is exactly what we are looking for — someone who is willing to share those feelings with us so that we can help them," says Abrams. "The handoff [to the longer-term resource] is actually a slow process."

At press time, the first patients to be enrolled in Access Health had not yet been in the program for 90 days, but some of them had already been connected with long-term resources, says Abrams. "We are still in the picture, though, because we want to make sure that before we close a case, the clients understand what they need to do," she says.

Use community partners

Many of the patients targeted for the program have complicated needs that bring them to the ED, says Jaquis. "They may have concomitant behavioral and somatic issues, they may be homeless, and they may not have insurance," he says. "They may be identified as being on medication, but then aren't compliant."

Abrams explains that she commonly works with patients who have a substance abuse problem, and this is often coupled with a mental health issue. "That is a big problem in Baltimore, so we do get a lot of clients who are either seeking prescriptions or they have substance abuse issues," she says. "We partner with many mental health organizations in the city to connect these clients with a treatment service and get them into counseling for the mental health issues."

Also, HealthCare Access Maryland has an entire department that is dedicated to homeless services outreach, adds Abrams. "We probably have eight or more clients who are homeless, and typically what we do is partner with the outreach program to [resolve the problem]," she says. "If they are homeless and living with a relative or a friend, then we will try to find them permanent, stable housing."

While issues such as homelessness and substance abuse come up often, the care coordinators also encounter patients with more unique circumstances. For instance, Abrams recalls one recent case that involved a man who was self-employed and uninsured, but he was very involved with fitness training, so he thought he was taking care of himself, she says.

"However, we discovered that he was over-utilizing vitamins and energy drinks, which brought him to the ED," says Abrams. "We needed to get him insurance right away because he required emergency surgery, so we were able to get that expedited within 48 hours."

Abrams also linked the client up with a nutritionist and an internal medicine physician so that he could follow up on his care and receive expert guidance to prevent a similar situation from happening again. "Everything worked out for him," she says.

While complex issues can be difficult to resolve in the emergency setting, patients can make progress when they are linked with appropriate support services. And even in the program's early days, it is clear there is ample need for this kind of help. "The care coordinators have already had about 90 patients referred to them, and they have been able to discuss their programs and services with these patients," says Jaquis. "Seventy-four of those patients have agreed to continue with those services, and the care coordinators have already conducted 30 home visits."

A big part of the care coordinator's job involves getting patients plugged into a medical home and educating them about when they should call their primary care physician or a specialist rather than visiting the ED, says Abrams. "We also want to make sure that when they have scheduled appointments for care, they follow up on getting required lab work completed and any other orders the physician discussed."

Educate providers

Getting the emergency providers on board with the program was not difficult, but it did take some time to bring them up to speed on what types of patients are ideally suited to this type of approach and how the program works, explains Jaquis.

To help educate providers about the program, Access Health conducts weekly in-service sessions, typically during scheduled meetings or physician huddles. During these sessions, the care coordinators provide updates about the program and solicit input on any challenges the providers have faced with the program, says Abrams. "We also check to see if there are any patients they didn't refer to us at the time of care, but now that they are thinking about it, may benefit from a follow-up post-discharge," she says. "We are doing all we can to educate the staff at Sinai, and a referral can come from anyone in the hospital as long as the client meets the eligibility qualifications."

While providers have been largely open to the program, there have been some technical hurdles in getting

the program up and running. "Our biggest challenge was connecting our data system to Sinai Hospital's data system," says Abrams. "The two systems are not actually able to communicate, so as a result, our staff members have to document more than once, into more than one system."

Ultimately, Access Health staff members were able to work around the problem, but it is an issue that hospitals should consider if they are interested in setting up a similar approach, says Abrams. "If it is possible to get your organization's data system to talk to the partnering facility's data system, that will save you a lot of time and energy," she says.

The goal is to eventually enroll 200 patients in the Access Health Program, but Jaquis emphasizes that the focus of the program is not to get people out of the ED, but rather to connect them with appropriate care and coverage. He notes that the care coordinators have already been able to link 10 of the patients who were identified as being uninsured with insurance. "This program is helping people find pathways to care that provide a better long-term outcome for them," he explains. "We are very connected to outcome measures with this program. It will be good see within the next six to 12 months how we are doing." ■

Understand, reduce HCW absenteeism

Why do most workers call in sick?

The answer should restore a little of your faith in humanity. For the most part, healthcare workers call in with legitimate illness.

In an era when the media image of nurses and other healthcare workers is tainted by cynicism, that conclusion may be somewhat surprising, but a recent study found that almost three-quarters of workers who call in sick are indeed suffering an illness.[1]

"I worked in occupational health in a hospital for 13 years and have been working in occupational health in manufacturing for 12 years, so I've seen a number of employees who have missed time from work," says **Candace Sandal**, DNP, MBA, an occupational health nurse practitioner who was principal author of the study about workers using sick time.

"It turns out that workers really are sick when they say they're sick," Sandal says. "I found in the study that workers do feel guilty when they miss work and they consider the impact it will have on their coworkers."

Investigators surveyed students of a large university who held jobs in various industries.

"We chose a university so the study wouldn't be linked to a particular workplace survey," she notes. "Of the people who responded, 73% said they call in sick because they are sick."

Of the 27% who called in sick when they were well, the non-sick reasons were varied but included the need to take care of a sick child, disliking their job, and needing a mental health day, Sandal says.

The study's findings suggest that hospital employee health programs could help reduce worker absenteeism through strategies that prevent and mitigate common worker illnesses, Sandal says.

"If they were in contact at the start of an illness then we can intervene and treat, so they don't need to miss work," she says. Instead, what typically happens is people hang in there with a burgeoning cold or sinus infection or other illness until they get sicker and sicker and have to miss work, she says.

Sandal offers these suggestions for hospital employee health programs:

• **Educate staff about common symptoms and the need for early treatment.** Pamphlets could be placed in hospital work stations, listing common symptoms of early upper respiratory infections, gastrointestinal illness, eye diseases, and rashes, which could indicate chicken pox or shingles. It's particularly important for hospital employees to report their symptoms early because of the potential of being contagious when working with or around patients, Sandal says.

• **Promote an on-site employee health clinic.** When new employees

COMING IN FUTURE MONTHS

- How to manage the obesity epidemic.
- Helping at-risk women have healthy pregnancies.
- Is your organization culturally competent?
- What healthcare reform means to case managers.

are hired, it's a good practice to give them a tour of the employee health clinic.

• **Meet with employees who have high rates of calling in sick.** "It's not always what it seems, and this is an occupational health nurse's role, not a manager's role because managers shouldn't get involved in health issues," she says.

• **Provide stress reduction education and programs.** Every unit in a hospital has its own unique stressors, Sandal says. "I worked in ICU for a long time," she notes. "I understand that critical care stress, but I haven't seen any research trend showing that one hospital unit is more vulnerable to stress than another."

Employee health can address hospitalwide employee stress by offering staff a stress reduction program. This could include providing a limited number of free visits with a provider who is skilled in stress reduction, on- or off-site, she suggests.

• **Change healthcare workers' "me-last" culture.** Nurses and other healthcare workers often operate within a culture in which they care about everyone else's health and welfare before thinking of their own, Sandal says.

Having an easily accessible onsite clinic for workers can help encourage them to seek help when they're beginning to feel unwell.

"Employee health programs should advertise what they're doing for workers and show the effect they're having on that population," Sandal says. "It's time and money well spent."

REFERENCE

1. Sandal CL, Click ER, Dowling DA, et al. The decision-making process of workers in using sick time. *Workplace Health Saf* 2014;62(8):318-324. ■

CNE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.
2. Scan the QR code to the right or log on to www.cmecity.com to take a post-test; tests are taken after each issue. 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 test, 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.

CNE QUESTIONS

1. According to Catherine M. Mullahy, RN, BSN, CCRN, CCM, who benefits when case managers work in a primary care practice?

A. The patients
B. The physicians
C. The case managers
D. All of the above

2. The goal of Sentara Healthcare is for its embedded case managers to have a caseload of how many patients?

A. 25
B. 75
C. 150
D. 200

3. The care coordinators at The Jackson Clinic are aligned with specific case managers at Cigna and have standing appointments to discuss particular cases and what interventions they need.

A. True
B. False

4. At Horizon Blue Cross Blue Shield of New Jersey, what group of patients do the population care coordinators focus on?

A. The top 5% to 10% of patients who are sickest but who potentially can control their conditions.
B. Patients whose health status makes them likely to become chronically ill in the future unless they take steps to change their lifestyles.
C. Patients who have frequent emergency department visits and hospital admissions.
D. Patients who have just gotten out of the hospital.

CASE MANAGEMENT ADVISOR™

United States Postal Service

Statement of Ownership, Management, and Circulation

1. Publication Title	2. Publication Number	3. Filing Date
Case Management Advisor	1 0 5 3 – 5 5 0 0	10/1/14
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Monthly	12	$419.00

7. Complete Mailing Address of Known Office of Publication *(Not printer) (Street, city, county, state, and ZIP+4)*
950 East Paces Ferry Road NE, Ste. 2850, Atlanta
Fulton County, GA 30326-1180

Contact Person: Robin Salet
Telephone: 404-262-5489

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not printer)*
950 East Paces Ferry Road NE, Ste. 2850, Atlanta, GA 30326-1180

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do not leave blank)*

Publisher *(Name and complete mailing address)*
AHC Media LLC, David Fournier, President and CEO
950 East Paces Ferry Road NE, Ste. 2850, Atlanta, GA 30326-1180

Editor *(Name and complete mailing address)*
Russ Underwood, same as above

Managing Editor *(Name and complete mailing address)*
Jill Drachenberg, same as above

10. Owner *(Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual owner. If the publication is published by a nonprofit organization, give its name and address.)*

Full Name	Complete Mailing Address
AHC Media LLC	950 East Paces Ferry Road NE, Ste 2850, Atlanta, GA 30326-1180

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☒ None

Full Name	Complete Mailing Address

12. Tax Status *(For completion by nonprofit organizations authorized to mail at nonprofit rates) (Check one)*
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☑ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months *(Publisher must submit explanation of change with this statement)*

PS Form **3526,** October 1999 *(See Instructions on Reverse)*

13. Publication Title: Case Management Advisor			14. Issue Date for Circulation Data Below: September 2014	
15.		Extent and Nature of Circulation	Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
a.		Total Number of Copies *(Net press run)*	85	71
b. Paid and/or Requested Circulation	(1)	Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541. *(Include advertiser's proof and exchange copies)*	59	55
	(2)	Paid In-County Subscriptions Stated on Form 3541 *(Include advertiser's proof and exchange copies)*	0	0
	(3)	Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution	0	0
	(4)	Other Classes Mailed Through the USPS	6	1
c.		Total Paid and/or Requested Circulation *[Sum of 15b. (1), (2),(3),and (4)]* ▶	65	56
d. Free Distribution by Mail *(Samples, complimentary, and other free)*	(1)	Outside-County as Stated on Form 3541	8	7
	(2)	In-County as Stated on Form 3541	0	0
	(3)	Other Classes Mailed Through the USPS	0	0
e.		Free Distribution Outside the Mail *(Carriers or other means)*	7	5
f.		Total Free Distribution *(Sum of 15d. and 15e.)* ▶	15	12
g.		Total Distribution *(Sum of 15c. and 15f)* ▶	80	68
h.		Copies not Distributed	5	3
i.		Total *(Sum of 15g. and h.)* ▶	85	71
j.		Percent Paid and/or Requested Circulation *(15c. divided by 15g. times 100)*	81%	82%

16. Publication of Statement of Ownership
☑ Publication required. Will be printed in the November 2014 issue of this publication. ☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner: *David R. Fournier* — Publisher & CEO — Date: 09/10/2014

I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including civil penalties).

Instructions to Publishers

1. Complete and file one copy of this form with your postmaster annually on or before October 1. Keep a copy of the completed form for your records.
2. In cases where the stockholder or security holder is a trustee, include in items 10 and 11 the name of the person or corporation for whom the trustee is acting. Also include the names and addresses of individuals who are stockholders who own or hold 1 percent or more of the total amount of bonds, mortgages, or other securities of the publishing corporation. In item 11, if none, check the box. Use blank sheets if more space is required.
3. Be sure to furnish all circulation information called for in item 15. Free circulation must be shown in items 15d, e, and f.
4. Item 15h., Copies not Distributed, must include (1) newsstand copies originally stated on Form 3541, and returned to the publisher,(2) estimated returns from news agents, and (3), copies for office use, leftovers, spoiled, and all other copies not distributed.
5. If the publication had Periodicals authorization as a general or requester publication, this Statement of Ownership, Management, and Circulation must be published; it must be printed in any issue in October or, if the publication is not published during October, the first issue printed after October.
6. In item 16, indicate the date of the issue in which this Statement of Ownership will be published.
7. Item 17 must be signed.

Failure to file or publish a statement of ownership may lead to suspension of Periodicals authorization.

PS Form **3526,** October 1999 *(Reverse)*