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Group visits are effective use of case managers' time

Pilot for chronic pain patients was a success

When **Ira Mandel**, MD, MPH, was a physician in private practice, he found that group visits were an effective way to cover disease-management issues with his patients with diabetes. As executive medical director for Health Integrated, a Tampa, FL-based provider of care management services, he adapted the group visit concept for telephone-based case managers.

"The idea of marrying group visits with complex case management is interesting. Since most case management is not done on site, we explored ways to hold a group visit on a conference call," he says.

Mandel and three case managers who manage the care of complex patients conducted two pilot projects for patients with chronic pain. After the pilot project, the company has begun exploring ways to expand the group visits for its case managers and disease managers.

The nurses in medical case management brainstormed about the condition they felt would benefit most from a group visit and came up with chronic pain, says **Robin Johnson**, RN, case manager at Health Integrated and one of the participants in the two group sessions.

"I wanted to start with chronic pain because those patients have so many psychological issues and they encounter so many biased feelings about people who are on chronic pain medication. It's an area where patients become hopeless, and we wanted to give them hope," she says.

The group got permission to involve patients from CoverColorado, a state-sponsored program for disabled people who are not eligible for Medicare or Medicaid and can't get insurance through their work.

The case managers went through their caseloads and identified 15 patients with chronic pain who would be good candidates for a group visit and approached them about participating in the session.

Seven of the patients expressed a real interest in the experiment, Mandel reports.

The company sent participants an agenda that listed what would happen during the session, goals of the meeting, potential topics for

discussion, and ground rules, along with information about chronic pain web sites, common problems, and opiates that might work when the physician has run out of options.

Ground rules included respect for each other's time during the meeting, keeping what was discussed confidential, avoiding being judgmental of or preaching to other participants, and emphasizing that the sessions are not designed to take the place of medical treatment.

"For the first call, we felt we needed to introduce them to the process so they would know what to expect and use the time well," Mandel says.

Health Integrated set up a toll-free one-hour conference call for each of the two sessions, allowing patients who wanted to participate to dial in.

The sessions were held early in the day at a time when chronic pain patients are most refreshed and able to concentrate, Mandel says.

When patients dialed in, they were cautioned to give only their first names and, as an ice-breaker, asked to tell about one of their hobbies.

Mandel led the session, encouraging participants to discuss common difficulties they encountered in seeking care and alternate approaches for overcoming the barriers.

After a while, the patients started interacting among themselves, offering tips and consolation, Johnson says.

"We just stepped out of the way and let them talk about what they wanted to," she says.

The patients like the fact that they were anonymous, Johnson says. "When they're talking among themselves, and they know only the first names of the other participants, they tend to say more because they feel safe."

The patients exchanged techniques, such as meditation, that they had found useful in coping with the pain. "The response from the patients was very enthusiastic. We did two sessions as a pilot, and those patients have been calling their case managers and asking when we are going to have another session," Mandel says.

Patients who participated in the session told the case managers that they were relieved to know that they weren't the only ones who were experiencing problems, Johnson says.

"Patients really love it. They're eager for someone to listen to them and to get more information about coping with chronic pain. I see group visits as a tool that case managers could use to effectively deal with a lot of different problems," Mandel adds.

For instance, several of the patients discussed how they had encountered physicians and other providers who did not take them seriously or treated them like drug addicts.

"Managing the care of people with chronic pain is not so much about behavioral change, but it does involve a lot of emotional issues. There's the stigma of taking narcotics and being regarded as drug addicts. These people feel that they are misunderstood. Because you can't see pain, people don't believe that they are really in pain," Mandel says.

The concept for group visits began in physician offices, he points out.

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Editorial Questions

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CoverColorado/Health Integrated Telephone Group Information Exchange Meeting

Suggested topics for discussion

A. Misperceptions by doctors (thinking you are a drug addict or just want drugs for inappropriate reasons)
B. Misperceptions by other people
C. Feelings that no one understands or believes your pain is real
D. How chronic pain messes up your life
E. How chronic pain can cause depression and how depression can make your pain worse — how do you adjust psychology?
F. Frustrations dealing with:
   1. Doctors who don't seem to help enough
   2. Insurance companies that won't cover what you need
   3. Lack of family/friend support
   4. Poor concentration, poor sleep, medication side effects, etc.
G. Medication treatments
H. Nonmedication treatments
I. High-tech treatments
J. Job and financial problems and worries
K. Success stories
L. Any other topic is fair game. Please suggest other topics.

Source: CoverColorado/Health Integrated, Tampa, FL.

"There are a lot of similarities between patients with chronic diseases; and typically, 90% of what occurs during an office visit is talking and 10% is the exam," he says.

Mandel's diabetes patients responded very positively to the group visits, bonding with each other and discussing topics they never would discuss one-on-one with a physician, he adds.

Case managers don't have the opportunity to meet their clients face-to-face in most settings but, like physicians who deal with chronically ill patients, they often find themselves covering the same issues over and over with every client.

"The challenge case managers face is that many of the interventions they need to apply for their patients address behavioral changes. Patients who don't understand their disease have problems with adherence, feel depressed, and believe that nobody else has the same disease," Mandel says.

A telephone group visit may not have the same impact as a face-to-face group visit, but it can work very well, particularly since patients don't have to leave their home to participate and can remain anonymous, he adds.

"One of the reasons group visits are appealing to practitioners is that you can spend time with patients more efficiently. They allow case managers to do more than just hand holding," he says.

Case management group visits allow patients to interact with other people who have the same problems. They can talk about what they are doing to cope and share each other's experiences, Mandel points out. "Group visits allow the most intensive level of care management for patients who need a lot of interventions and are not getting the care they need," he says.

One of the challenges the Health Integrated case managers faced was identifying enough patients with similar conditions who were willing to participate in a group visit.

Chronic pain was a leading candidate for the pilot project because it's a very common condition that causes patients a lot of frustration, Mandel says. "There is strength in numbers. It's the group talking, rather than just one patient, and often one person will ask questions about things the others were too bashful to bring up." ■

In-house program gives support at stressful time

CMs work with breast, lung cancer patients

As part of its mission to provide peace of mind to members, Premera Blue Cross has developed an innovative case management program to help members with breast and lung cancer understand their disease and make informed choices about their treatment options.

The company initially worked with a vendor to develop and provide comprehensive disease management services for members with breast and lung cancer, then transitioned the services in-house.

The Mountlake Terrace, WA, health plan has five nurse case managers with oncology experience and additional training who are dedicated to the program. They carry a caseload of 35-45 members at a time, working closely with members to educate them about their condition and treatment options and to help them avoid complications during treatment.

The case managers follow the members who are in active treatment and who have end-of-life needs.

After a case is closed, they follow up every three months to see how the members are doing and determine whether they need to be called more frequently.

The cancer management program is a combination of traditional disease management and case management, points out **Golda Posey**, RN, MS, manager for the Premera's disease management program.

"We are providing interventions from traditional case management combined with population health or disease management. We want to make contact with the member early on in active treatment and continue follow up to make sure that we are able to offer support and education for condition changes that may occur months after active treatment has been completed," she says.

Breast cancer and lung cancer were near the top of the list when Premera studied the most troubling diagnoses for members in 1998 and contracted with the vendor, says **Liz Grunte**, RN, disease management program administrator.

Originally, the vendor provided a broader population-based program for cancer patients. Later, Premera decided to concentrate on providing individual case management targeted only to the members who would benefit most from the program.

"One of the things we learned in our experiences with the vendor was that simply monitoring the patients or having them be part of the program when they didn't really have any needs didn't provide the kind of value that our one-on-one case management can provide. We built on what we learned while we worked with the vendor and, integrating a dedicated team of Premera disease-focused case managers, brought the program in-house," Grunte says.

The program is offered to Premera members with a primary diagnosis of breast cancer or lung cancer whose employers have purchased the service. Patients are identified by referrals from health plan staff, providers, and an examination of claims data.

When the case managers receive a referral, they research the Premera claims to find out the stage of cancer, what treatments the patients have had or are undergoing, and where the patients are in the course of treatment, says **Catherine Kinnunen**, RN, oncology case manager.

Then they call the member and do an assessment to find out their needs. "We are getting in touch with members at a time when they feel they have the least control over their lives. The purpose of the program is to empower the member to get optimum outcomes from the care they receive," says **Mary Murray**, CCM, RN, CPQ, manager of case management.

The case managers educate the members about national cancer treatment guidelines and answer any questions the members may have.

"Oncology nurses love to teach. We provide a lot of information and support. We provide education verbally on the telephone and supplement it with written information and refer them to approved Internet sites. We have a lot of members who are computer literate but don't want to surf for information about their disease. We give them places they can look," Kinnunen says.

Premera's oncology advisory physician group reviews the materials and Internet sites.

"A key piece of the program is providing resources. It's a time when people are overwhelmed and need someone to guide them to the information they want to know from sources that are reliable," Grunte says.

Helping to ask questions

The number and intensity of interventions depends on the stage in the disease process, Murray adds.

"We get some referrals right after the patient has gotten the positive biopsy and others after they are in the latter stages," she says.

Those who have just received the diagnosis or those who are in the final stages of the disease may need a lot of help. Patients who are completing their treatment may not need a lot of interventions.

The case managers work with the physicians who created the treatment plan for the patients, often helping the members come up with the right questions to ask their physician and helping them phrase the questions correctly.

"When people are in a crisis in their lives, they may not know which questions to ask their doctor and how to ask them. We're there to help them with the questions," she says.

If a member is referred at the beginning of the treatment, the case managers tell them what to expect from the first visit with the oncologist and what to expect from their treatment.

The case managers typically call patients who are recently diagnosed and just starting their treatment twice a month or more, depending on their needs, then taper off to once-a-month calls, Kinnunen says.

"Being diagnosed with cancer puts people in an emotional tailspin. We have all had patients call us

when they are very depressed. We work closely with them and their family members if we have permission to speak to them, and refer the members to our behavioral health case managers if they need more support than we can give," she adds.

Members are encouraged to call the case managers with any questions or concerns they have. Some members call the case managers frequently. Others, who continue to work during their course of treatment, often don't have time to call.

"We make sure we do the outreach to these members and make sure everything is OK. How long we follow them depends on the patient. I'm still following some patients nine months after the program began, but there are a lot of cases that have been closed," Kinnunen says.

The case managers and the patients make a joint decision on when the case is closed. "As long as both feel there is value in the contact, we will continue to call them. They know that they can be discharged and still have the ability to call us back if they need us," Grunte says.

"Calling the member is the most important part of the service. It gives them help with managing their lives at a difficult time," Posey says.

When members are approaching the end of life, the case managers do whatever they can to ensure that the patients are comfortable, starting with assessing when the member needs hospice care.

"It can be difficult because sometimes patients and family members are in denial. People have a misconception about hospice care. They think that if you're there, you're going to die shortly. Our goal in supporting the physicians' and members' decision to involve hospice is to make the members as comfortable as possible and to provide assistance with end-of-life issues," she says.

The case managers educate members and their families on the kinds of services that hospice offers and when the services are appropriate and on eliminating misconceptions, such as the idea that those patients who are receiving chemotherapy or radiation for palliative purposes can't receive hospice care.

Having case managers work with cancer patients saves money because the members have appropriate information for making health care choices and because the case managers often can help the members prevent complications, Posey says.

For instance, when members receive chemotherapy treatments, their immune system is suppressed and they are more likely to get an infection if exposed to outside forces. "Whenever a patient with a suppressed immune system goes into the hospital because of an infection, their stay can be quite lengthy," Kinnunen says.

The case managers work closely with the members providing verbal and written education on how to avoid infection. "Most people know to avoid crowds, but we caution our members who are farmers to make sure they stay away from the barns and to make sure their family members wash and change clothes before coming in touch with them. Animals are a big source of infection," she says.

With another member, a teacher, the case managers cautioned her to stay behind her desk and not walk up and down the aisles to be exposed to coughing and sneezing students. "We teach them to avoid crowds, to wear a mask if they have to go out, and to practice good hand-washing precautions," Kinnunen says.

The case managers emphasize that their role is to support the physicians and their treatment plans.

"The only time we might interfere at all is if a member wants to investigate a really alternative source of treatment. In that case, we would caution the member and, if necessary, make contact with the member's physician to make sure he or she is aware of what the member is considering. We want the member to be safe as well as informed about alternatives," she says.

"The case managers are in a position to identify side effects and complications that the provider may not know about. In that case, they make sure the provider knows and can adjust the medicine or otherwise help the member handle the complication," Kinnunen says. ■

GUEST COLUMN

Voc rehab CMs advocate for injured workers

Provide employees tools to make good decisions

By **Karen Provine**, MS, CCM, CRC, LPC, CDMS
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When a person acquires a disability and can no longer perform the required tasks of his or

her job, vocational rehabilitation is needed to help the individual return to work in another capacity. To facilitate this process, an analysis of transferable skills should be conducted up front. This early vocational intervention will help identify the necessary training and help empower individuals to make informed choices for themselves.

The role of the rehabilitation case manager or vocational professional is to advocate on behalf of the person by identifying the best ways to return to work. However, this can sometimes be a source of conflict, especially if the case manager or counselor and the individual hold different ideas about the best way to reenter the work force. Understanding the responsibilities and limits of the process can help rehabilitation case managers and other vocational professionals take a more proactive role to assist individuals with disabilities to become productive again.

According to the Council of State Administrators of Vocational Rehabilitation, 49 million Americans have a disability. Unemployment for Americans with disabilities is estimated to be as high as 70%, with 30% of these individuals indicating they want or are able to work. Rehabilitation case managers and vocational rehabilitation professionals have an opportunity to help these individuals with disabilities to enter or return to the work force.

Consider the case of George, who had an undergraduate degree in science and work experience including being a middle school teacher, a pharmaceutical compounder, and a construction worker. Past surgeries for knee injuries and repetitive stress injury in his right (dominant) hand, however, made him unable to perform the physical demands of his usual occupations, which required prolonged standing, reaching, and handling.

An analysis of his transferable skills revealed a wide array of knowledge and attributes, including: production and processing, rate control, operation monitoring, administration and management, reading comprehension, active listening, writing, speaking, learning strategies, instructing, synthesis/reorganization, implementation planning, operations analysis, time management, and attention to detail.

Training in job-seeking skills helped George identify and access sources of job leads, create a resume, answer interview questions, and manage his disability on the job. As a result, he was able to tap his network of contacts to identify, apply for, and obtain employment with benefits as a quality assurance analyst at a pharmaceutical company. The position allowed him to utilize his skills and education, while minimizing his limitations. George was very pleased with the outcome.

"I've worked all my life in physical labor jobs. It's such a relief to be able to do desk duty. Thank you," he told his case manager.

As George's case illustrates, the role of the vocational rehabilitation counselor and/or case manager is to assist the client in receiving maximum benefit from vocational services. This advocacy role, helping individuals to access the services they need in a timely and efficient manner, shows how the specific role of the rehabilitation case manager or vocational rehabilitation counselor relates to the broader field of case management.

Similarly, vocational rehabilitation professionals face challenges that are similar to those that case managers in general encounter. Our role is to provide individuals with the necessary tools to make informed choices and decisions regarding the services and options available to them. There are limits, however, to what we can provide. We cannot give someone carte blanche to pursue anything they wish; an injured production worker cannot decide to go to law school at someone else's expense, for example. Nor can we sit idly by while clients set themselves up for failure.

Communication, info sharing are critical

When clients have unrealistic employment goals or expectations regarding the scope of services they are entitled to receive, communication and the sharing of information are critical. This often begins with an analysis of transferable skills, which to be most effective should be conducted up front. Traditionally, rehabilitation case managers and other vocational professionals have used resources such as the Classification of Jobs based on U.S. Department of Labor data to manually identify worker skills, which may be deployed in other jobs. Now, computerized methods and software (such as OASYS by VERTEK and a component of the Choices program by Careerware) have greatly facilitated the process.

Performing a skill analysis early on in the process helps individuals return to work more quickly, and typically at a higher wage than if they started a new career as an entry level employee. Other benefits of this early intervention include:

- Gaps or interruptions in an individual's work history are minimized.
- Facilitating the return-to-work process may reduce extended disability payments and avoid provision of nonessential services.

• Reliance on agencies is reduced and the likelihood of repeat applicants is decreased.

• The job seeker is more in control of his or her own destiny and empowered to consider a range of alternatives. This allows the individual to make decisions and accept responsibility for results.

The case manager or vocational counselor must use tact and sensitivity when reviewing negative results of the skills analysis with the client to avoid damaging what may already be a fragile self-esteem. Clients who insist on formal retraining, but who do not appear to have the potential for success, may be supported on a semester-to-semester basis, with the understanding that if they are unable to meet the required academic standards, a direct placement plan will be developed and implemented.

One of the best options, providing a client with income and new skills, is on-the-job training. Many employers are receptive to this type of program. Helping a client obtain employment at a company that offers educational benefits or tuition reimbursement is another possibility. Case managers and vocational professionals also can help clients identify and obtain alternative sources of funding, such as financial aid, public assistance, or disability benefits, if appropriate, to help them pursue their goals independently.

When a person with a disability wants to return to work, the rehabilitation case manager or vocational professional can help identify resources and employment options. For this to be most effective, the analysis of transferable skills and training in independent job-seeking skills should be done early in the rehabilitation process. This puts the emphasis on the desired end goal: helping the individual pursue realistic and viable options to return to work.

[Editor's note: ***Karen N. Provine****, MS, CCM, CRC, LPC, CDMS, is a commissioner of the Commission for Case Manager Certification (CCMC), for which she also serves as secretary. The CCMC is the first certifying body for case management professionals to be accredited by the National Commission for Certifying Agencies. URAC also has determined that the CCM credential is a recognized case management certification. For more information or to obtain an application for the CCM, contact the CCMC at (847) 818-0292 or see the web site at www.ccmcertification.org.*

Provine also is a vocational rehabilitation counselor with the New Mexico Division of Vocational Rehabilitation. Her responsibilities include coordinating vocational, medical and educational services for eligible persons with disabilities, providing placement assistance, and developing return-to-work programs.] ■

Malingering employees? Fear may keep them away

Fear of pain or reinjury often slows return to work

A customer service associate for a large company, whose days at work are spent taking customer calls at her desk, injures her back and is determined by her company's physician to be disabled. Six weeks later, she still has some back pain, so her physician does not clear her to return to work; however, she goes on vacation with her family, plays tennis, and swims.

Does this employee fit the definition of a malingerer — someone who is evading duty or work by pretending to be incapacitated? Not likely, says **Dave Hubbard,** RN, a disability case manager for Fort Dearborn Life, a BlueCross BlueShield subsidiary in Dallas. What is most often true in such cases, he says, is that a patient with some real — though not incapacitating — pain is afraid or unwilling to push his physician for a return-to-work (RTW) order; or the physician is not experienced enough in disability evaluation or not familiar enough with the employee's job description to determine that a little back pain will not harm the patient or affect her ability to return to work.

There are ways for occupational health practitioners to better serve both their employer companies and their injured workers, he says, and a lot of it boils down to motivation — motivating doctors to learn patients' job requirements, motivating patients to go back to work even if they are not at 100% of their previous ability, and motivating employers to want employees back at less than 100% ability at first.

"I often think the term malingering is misused when in fact what is actually being referred to is an individual who is less than motivated to return to work and who, with minimal effort, knows that they can remain off work and continue to receive an income," says Hubbard.

Sometimes, the patient is motivated by the comfort of remaining off work while still drawing income. But often, there's more to it. "Sure, they get more free time to spend on leisure activities, with the family, watching TV, surfing the net," Hubbard points out. "They also do not have to deal with a supervisor. It's often less stressful than work."

But perhaps more importantly, many injured employees believe they simply cannot go back to

work. "In the patient's mind is the worry the injury/illness will get worse if they return to work," he says. And the employee's physician and employer often share this misconception.

Many injured workers believe they are not obligated to return to their jobs until they are completely symptom-free, Hubbard notes. "Quite honestly, it has to do with the physician and the employer," he says. "The employer often de-motivates the employee, saying the employee has to be 100% [recovered or healthy] before returning. I say, 'What's 100%?'"

R.H. Haralson III, MD, MBA, FAADEP, president of the Chicago-based American Academy of Disability Evaluating Physicians (AADEP), contends that fear is a big factor in patients not returning from disability when it's actually in their best interest to get back to work. "Workers who are injured are frightened. Some are frightened by the injury itself and the fact that they might not recover completely. If it is a back injury, some are frightened by the specter of paralysis, despite the fact that paralysis rarely occurs," he says. "They also are frightened by the specter of never recovering, since they all know someone with a back injury who remains totally disabled. They are worried about being able to earn a living for their family."

Haralson says employees sometimes have been told by co-workers that their companies are going to take advantage of them, or they are suspicious of the company doctor and wonder if he or she is siding with the employer and will rush the employee back to work too early. "They are encouraged to act sick, for they are rewarded for being sick; and the sicker they are, the more they are rewarded."

Studies are showing that with many injuries or other disabilities, returning to work can be a highly effective part of the recovery process, Hubbard says. "People get better quicker, with less residual pain, when they return to work," he says. "Studies have shown that there is an eight times lower incidence of chronic pain when they go back to work than when they stay home, and at eight to 12 weeks [of an employee being off work on disability], the chance of that employee ever returning to work drop to 50%."

James R. Garb, MD, director of occupational health and safety for Baystate Health System based in Springfield, MA, says Baystate has a return-to-work philosophy for that very reason, saying, "Work is therapeutic for people who are injured."

Hubbard and others agree that returning to work does not always mean an immediate resumption of all the duties carried out before the employee went on disability. Some modifications may be necessary for a while, particularly when the employee's job requires lifting or repetitive motions or activities that would exacerbate the pain or injury that led to the disability in the first place.

An understanding of the employee's job is critical for any clinician making a determination of return-to-work eligibility, as is considering each employee individually in determining what 100% ability is for that person, he notes.

"My question is, are you talking about 100% [ability] of a 22-year-old, 6-foot-tall, 200-pound male, or his female co-worker who is 60 years old and overweight?" asks Hubbard. "There's often not a true standard, and lots of employees might use [applying the same standards to both types of the employees just described] as a reduction in force program, to get rid of employees they want to get rid of."

Getting an employee back to work takes motivation on the parts of the worker, his or her employer, and the evaluating physician, and each can have reasons to expedite or delay the return to work, experts say. The employee might want to return to work, but fear that if he or she still has any remnant of pain, it's not safe to go back. On the other hand, he or she might be reluctant to give up the vacation-like conditions of staying home and drawing partial income. The physician may rely too heavily on the patient's own evaluation of his or her pain, and without a clear understanding of the worker's job duties, might be reluctant to order him or her back to work when, in fact, it would be safe to do so.

The employer might place too much emphasis on having the employee be immediately at 100% ability upon return to work, when making some concessions for rest breaks or reduced physical activity would return the employee to some level of productivity and get him or her back to full productivity sooner.

If an employee is concerned about some remaining pain but is otherwise physically able to return to work — and, indeed, returning to work would speed recovery — the physician needs to step in, Hubbard says. "Unless a physician sits down and says, 'Excuse me, this is going to take a few weeks, but you'll get over it; and if you go back to work, you'll get better faster,' then the patient won't know that the pain is normal and not a reason to not return to work," Hubbard points out.

On the other hand, sometimes it's the doctor who needs the push. "Many physicians are not trained in the area of disability evaluation, don't

understand the evidence-based medicine that's out there, and don't understand the necessity of returning to work in a timely fashion," he says. "AADEP is doing a lot to educate physicians and nurses in this area."

Some of the employers Hubbard deals with "would rather have nobody in a chair than have someone there who is missing an hour of work a day while they throw up or do some stretching," he says. "We need to be thinking of how we can accommodate these employees on the job. It takes very little, often, to bring them back to work, but the employer doesn't ask the doctor what that is, and if the doctor doesn't have a clear idea of the job requirements, he won't know what accommodations can be made."

Garb says that unless an employer tells the physician what a worker's job entails (e.g., heavy lifting, repetitive motion, or sedentary work), the physician only can rely on what the patient tells him or her.

Hubbard, the disability case manager, says he asks physicians what their understanding of patients' job requirements really are — sedentary, light, or medium work. "Many check off that they're unaware of what the requirements are, and they'll usually check off at least one grade higher [than the requirements actually are]," he says. "Unless they have experience evaluating disability, physicians don't ask what somebody does, and even if they do, it doesn't mean the patient is really going to be honest with them."

Besides checking on an employee's convalescence while he or she is out of work, the occ-health manager can monitor whether the patient is receiving all the care he or she needs. "Professional athletes are given trainers and get back out there, but someone who is the sole support of their family is not given the training and support to bounce back as quickly as they should," Hubbard points out. "You have someone with a total knee replacement, who is told how to do physical therapy and then sent home with instructions to just do it, and doesn't do it as it should be done, has to go back in for manipulation and then back to physical therapy, and you lose eight more weeks of work."

Hubbard references a published study examined a random sample of adults living in 12 metropolitan cities in the United States who had acute and chronic conditions and preventive care, showed that those studied received only about 58% of recommended follow-up care.[1] "If only that many receive recommended care, what percentage of patients with claimed disabilities are likely to return to work in a reasonable period of time?" Hubbard asks.

The injured employee who decides he'd rather not go back to work — or worse, the employee who decided disability is a way to get out of work in the first place — poses a different challenge. According to the American Psychiatric Association, malingering can be expressed in several forms, ranging from pure malingering, in which the employee falsifies all symptoms; to partial malingering, in which the person has true symptoms but exaggerates the impact the symptoms have on his or her ability to function; to falsifying symptoms of an injury or disease when the actual problem is something else, such as substance abuse.

Garb offers some examples of what he calls "problem claims" pertaining to injured workers, and some suggestions for minimizing problems. Company occ-health or human resources personnel should contact injured workers regularly, in a nonthreatening manner, to ask how they are doing, he says. This lets the injured employee know that there is an expectation that he or she will return to work and that the employer wants them back.

According to Garb, more than two months out of work is a signal of potential delay in returning to work; he says he has encountered very few conditions that should keep an employee home that long.

Other indicators of possible true malingering include high absentee rates prior to the injury, reluctance to cooperate with treatment, inconsistent or nonorganic physical findings, two or more weeks of hospitalization, disability out of proportion to the injury, leaves that are extended just before the scheduled return to work, history of alcoholism or substance abuse, litigation pending, labor relations problems, and recent divorce or other family crisis, Garb states.

Reference

1. McGlynn EA, et al. The quality of health care delivered to adults in the United States. *N Engl J Med* 2003; 348:2,635-2,645. ■

Tracer methodology focuses on patient care

Pay less attention to manuals, more to safety goals

Midcycle self-assessments, tracer methodology, and less emphasis on examination of policy books are signs that the new survey process implemented by the Joint Commission on the Accreditation of Healthcare Organizations is truly different from the survey process of the past.

Although a change in any process to which people have become accustomed is uncomfortable, home health managers who have undergone surveys in 2004 report positive reactions to the new process.

"I like [the survey process] better this year than in previous years," says **Laura Hieb**, RN, MBA, administrator of Bellin Home Health in Green Bay, WI. "Surveyors used to focus on policy manuals and documents without any pattern or real objective. Now, everything the surveyor asks to see is based upon the patient who is being followed," she explains.

The use of a tracer methodology for a survey means the surveyor follows the path of a patient throughout the patient's encounter with the home health agency. That might mean the surveyor starts with the patient's records from the hospital and then follows the patient through referral, admission, care, and discharge. As the surveyor follows the patient's record, he or she talks with employees who are responsible for different aspects of the patient's encounter.

One of the Bellin Home Health patients who was traced was a patient who received services from the home health agency, the durable medical equipment company, and IV services. "The surveyor rode to the patient's home with the driver delivering the IV product, then stayed with the patient a good part of the day as our home health nurse and the IV nurse made their visits," Hieb explains.

"Throughout the surveyor's stay, she asked nurses how they handle different situations that might arise with a patient's care. She also talked with the patient, asking questions about who should be called for assistance with equipment or medications," Hieb adds. It was clear from the patient's responses that the home health agency, along with the other services, had done a good job educating the patient and making sure the correct phone numbers were handy, she notes.

It still is important to keep employee records up to date, she points out. "Although the surveyor didn't look through all of our personnel records, she did ask to see the files of four or five employees who were involved in the traced patients' care," Hieb explains.

Because the new process focuses more on actual patient care rather than paper documents, staff members have more direct contact with surveyors and often are the home health representatives questioned about processes rather than managers.

At the same time, home health employees may be the best prepared to interact with surveyors of all health care-related staff, notes **Judy Falkowski**, RN, BSN, director of Bay Area Hospital Home Health Care in North Bend, OR. "Home health staff members are accustomed to unannounced visits from state surveyors all the time. My staff have learned that the best way to show off the quality of care we offer is to do so while riding with a surveyor on a visit," she adds.

Questions that surveyors ask are prompted by what they see in the documentation or by what the staff member or patient says is being done, Falkowski explains. For example, when medications for a diabetic patient are discussed, the surveyor asks what education is provided and whether other services are consulted for advice and information, she adds.

Surveyors also are focusing on national patient safety goals, Falkowski says. "They want to see that staff members, physicians, and clients understand safety and know what to do if an alarm on a pump goes off, for example. The surveyors aren't looking for perfection," she says.

"What they do want to see is that your agency has systems in place to promote safety and to protect patients," Falkowski adds.

In one of the open forums held by the surveyors with representatives from all departments of the hospital, surveyors did not ask people to describe how they were meeting the goals. Instead, they asked, "What do you know about the national patient safety goals?" Hieb says. "That question led into other questions about how we address medication safety or improve communications," she notes.

While some home health agencies may feel let down that the surveyor doesn't spend more time in home health as they did when surveys were conducted separately, Hieb says the survey of her durable medical equipment company was the most extensive she's ever seen. "One of our surveyors happened to be a respiratory therapist, so our logs for equipment checks were reviewed, and he went on visits with the respiratory therapist," she explains.

In the home health agency, there were two surveyors who spent about four hours each looking at different patients, Hieb adds.

Don't forget that even though your home health agency is part of a hospital, you still need to have your own emergency management plan in place, Falkowski warns. "I am used to no recommendations or conditions in my surveys, so I was surprised to be hit with a recommendation related to E.C. 410, the standard that states that the organization must have an emergency management plan. My plan that I relied upon was basically the hospital's plan with a few modifications for home health," she says.

"The surveyor pointed out that, because home health differs from the hospital, it should have its own unique plan that does tie into the hospital's plan," Falkowski explains.

By using a hazard analysis tool, Falkowski was able to identify the most likely emergencies that her agency would face and develop a plan to address them. Within the plan, she addressed the possibility of receiving large numbers of admissions from the hospital as the hospital prepared to receive victims of an emergency. "We looked at how we would handle these admissions with and without power," she adds.

Infection control is another area upon which the surveyors focus, Falkowski says. On one of the patient visits, the surveyor asked the home health nurse if she had protective equipment for drawing blood.

Although the nurse did have the equipment, she did not have a hard container in which to transport used sharps, she says.

"The nurse was not scheduled to draw any

CE questions

17. The nurse in medical case management at Health Integrated in Tampa, FL, initially decided patients with _____ would benefit most from a group visit.
A. Diabetes
B. Chronic pain
C. Asthma
D. Congestive heart failure

18. Patients eligible for Premera Blue Cross' breast cancer and lung cancer case management programs are identified through ___.
A. Referrals from health plan staff
B. From providers
C. From an examination of claims data
D. All of the above

19. How many Americans have a disability, according to the Council of State Administrators of Vocational Rehabilitation?
A. 49 million
B. 62 million
C. 67 million
D. 92 million

20. Studies have shown that there is an eight times lower incidence of chronic pain when employees on disability go back to work than when they stay home, and at eight to 12 weeks (of an employee being off work on disability), the chance of that employee ever returning to work drops to ___.
A. 30%
B. 45%
C. 50%
D. 75%

Answers: 17. B; 18. D; 19. A; 20. C.

CE 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 those issues affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities. ■

blood that day, so she did not have the container," Falkowski explains.

She suggests that any employee who might draw blood be prepared with all of the equipment, including containers, regardless of what patients may be scheduled on that day.

While the survey may be easy for most home health agencies, the periodic performance review (PPR), the midcycle self-review now required by Joint Commission, presents more of a challenge, says **Jodi Brown**, RN, BSN, director and administrator of Alcovy Home Care in Covington, GA.

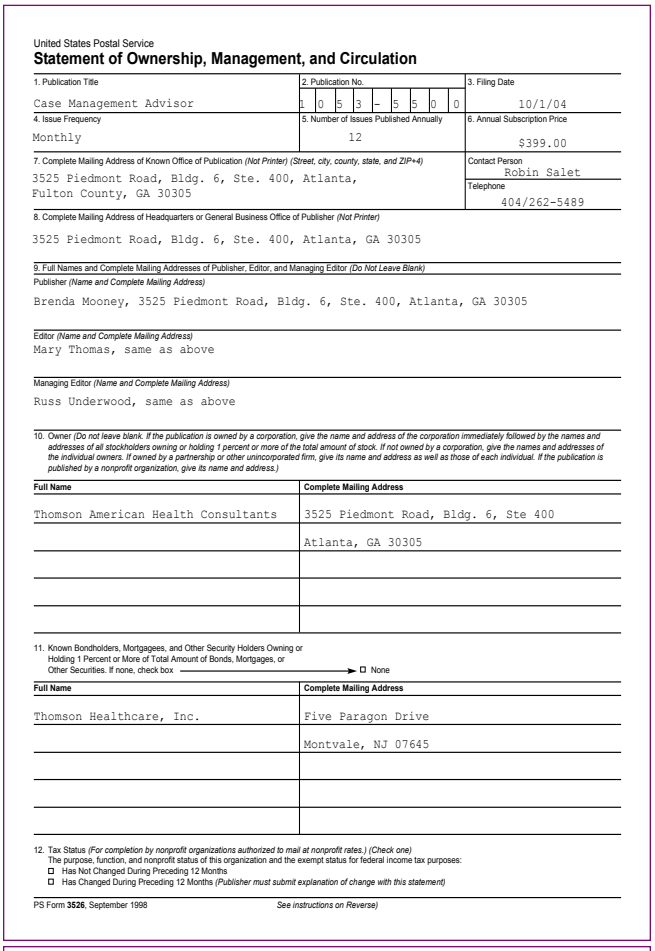
"It is very time-consuming, especially for a small agency," she says.

"We have received feedback that home health agencies find the PPR difficult," admits **Maryanne L. Popovich**, RN, MPH, executive director of the home care accreditation program. Although it is time-consuming, the review is very helpful as organizations target areas for improvement prior to the Joint Commission's survey.

"I went through the on-line tool, reading every section to determine which ones applied to us," Brown notes.

For the standards that apply to home care, she either completed the form stating whether the agency met the standard and how, or she pulled out sections for her nurses to complete if they were better qualified to complete the form. "My nurses weren't excited about the extra work, but it was the only way to complete it," she says.

Although the work to complete the self-assessment was split up, Brown says, staff discussed the completed information as a group. This is one way to ensure that all of the information is accurate and to identify areas for improvement and develop plans of action, she adds. ■



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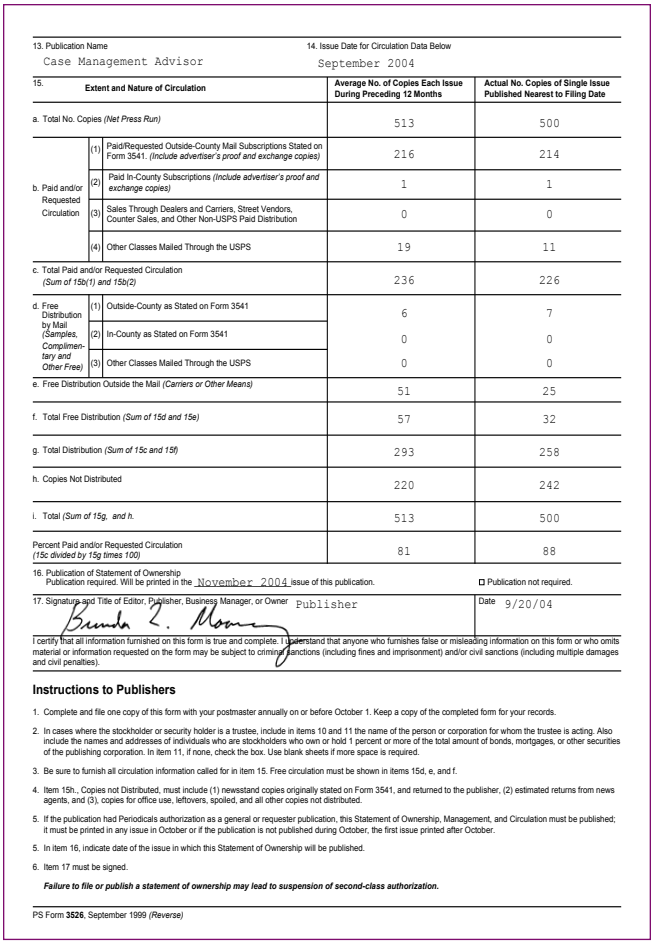

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Case managers still are fighting to prove their value

Challenges, opportunities are in the future

Salaries for case management are increasing, but the vast majority of case managers are working far more than the traditional 40-hour week, according to the results of the 2004 *Case Management Advisor* Salary Survey.

The 2004 survey was mailed to readers of *Case Management Advisor* in the June issue. More than half the respondents (58%) were case management directors. Almost all others were case managers.

Respondents to the survey report putting in long hours. In fact, more than 80% report working more than 40 hours a week, with 21% working more than 45 hours a week.

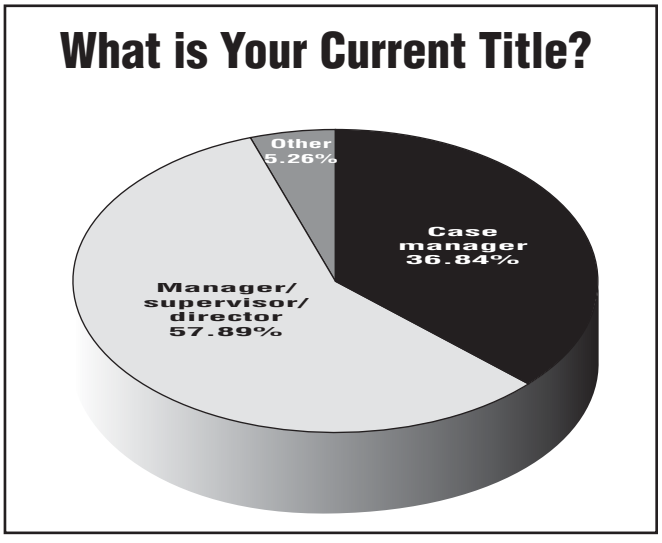
At the same time, 95% of respondents reported an increase in salary during the past year. The highest percentage (47%) reported getting a 1% to 3% raise, followed by 37% whose salary increases were between 4% and 6%.

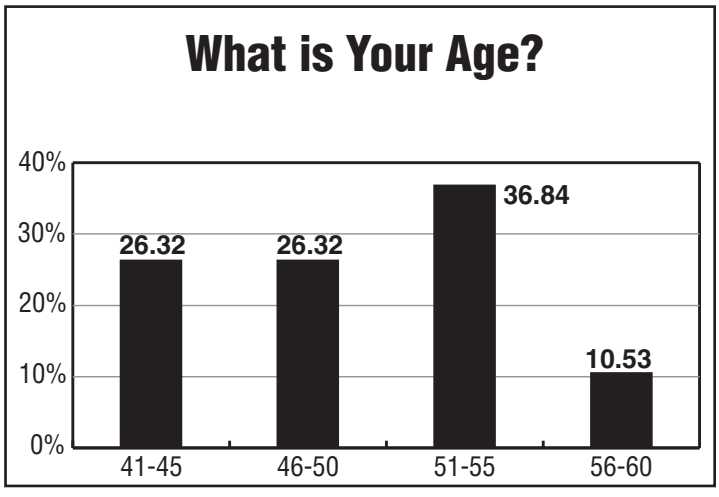
About 63% of respondents to the survey report salaries in the $50,000 to $80,000 range, with about 5% reporting salaries in excess of $100,000 and 21% reporting pay of less than $50,000.

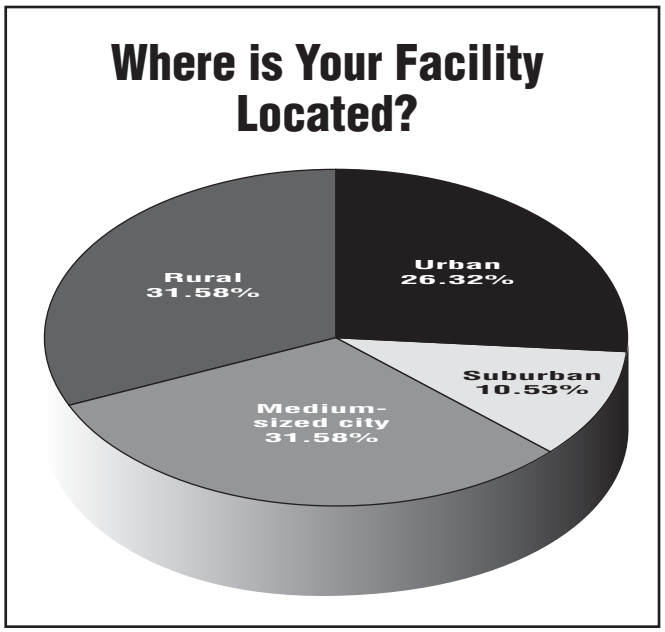
Salaries still are an issue when it comes to recruiting and retaining experienced case management staff, case management directors say.

Disparity in pay by region

Case management departments have problems recruiting at some hospitals because pay for case managers is less than the pay for staff nurses, says **Toni Cesta**, PhD, RN, FAAN, vice president,







patient flow optimization for North Shore-Long Island Jewish Health System in Great Neck, NY.

There's a big disparity in pay for case managers both by region and by organization. Sometimes case managers are paid at the clinical nurse specialist level; sometimes at the management level, and sometimes at the staff level, Cesta adds.

"In a lot of areas, case managers don't make what nurses make, and that makes a big difference," adds **Mary Ellen Beasley**, RN, BSN, division director for case management for HCA's 15-hospital West Florida division with headquarters in Palm Harbor, FL.

Beasley has had to replace five case management directors in the last year because they found jobs that paid more or changed careers paths.

"Some of them left nursing altogether, going into real estate or other professions. It wasn't just about moving up to be a nurse or case manager at a different facility," she says.

Not enough experienced case managers

Finding an experienced and competent person to fill the case management director's job presents a major challenge because case management is a fairly new field and there aren't a lot of experienced people available, Cesta adds.

"It's difficult to run an integrated case management department. A lot of people have been plopped into case management by default. It takes years to really understand the complex job of case management. We just don't have people who started out as an assistant director and came to move up to director," she says.

Case management directors find the nursing shortage another challenge to finding experienced staff to manage patient care.

"You can't just walk into this type of job. You need a wide body of knowledge, and it takes a while to get somebody trained," says **Sharon Simmons**, CRNP, MSN, CNOR, director of clinical excellence for St. Vincent's Hospital in Birmingham, AL.

Multiple skills are needed

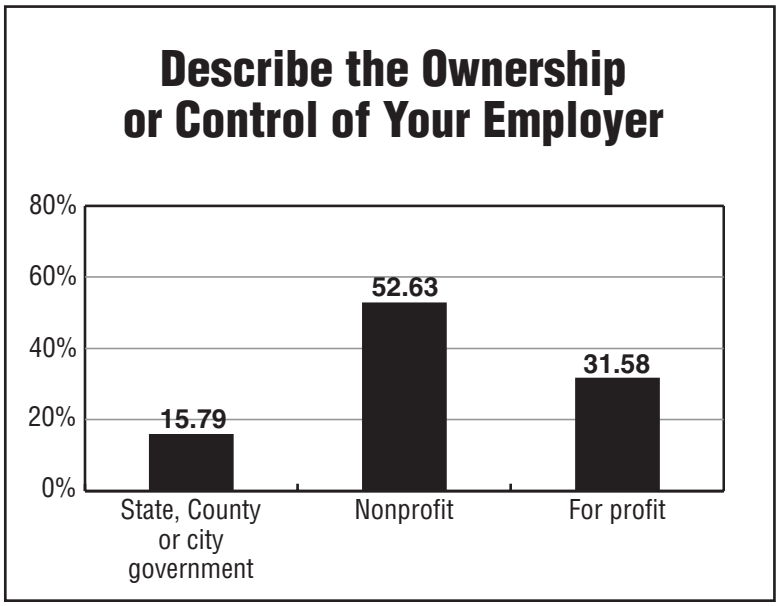
Often, administrators think that case management is less difficult than nursing because it doesn't involve direct patient care, Cesta points out.

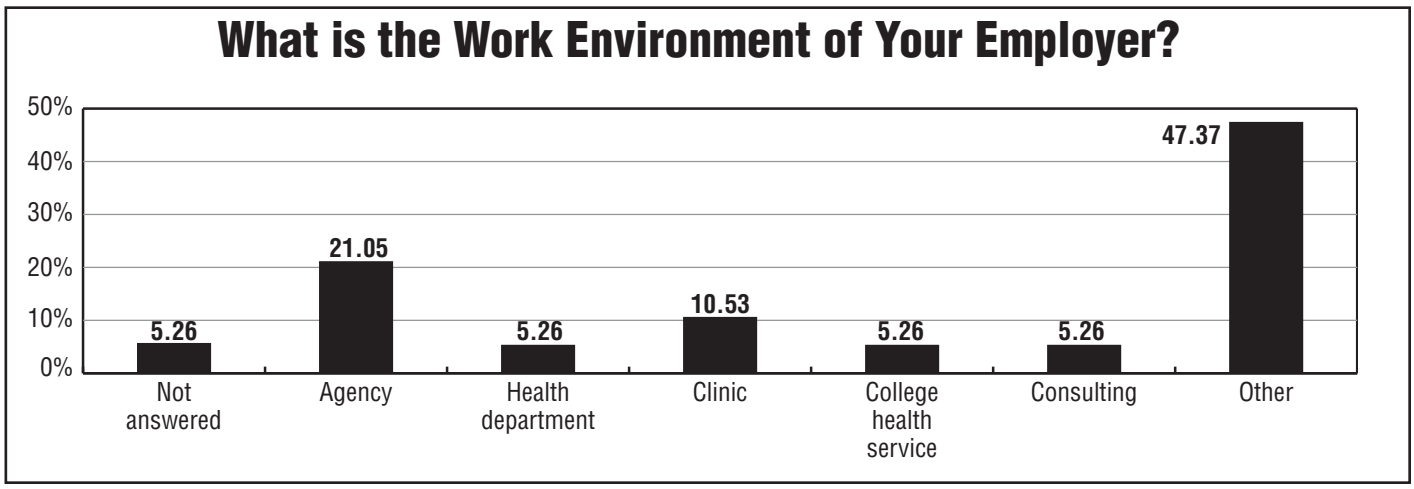
On the contrary, a good case manager is someone who has extensive clinical experience and multiple skills, she adds.

"Case managers are being asked to do more and do it faster and better than ever, " Beasley says.

The question is: Just how much more can case managers take on and still do it appropriately, she adds.

Case management has become a complex specialty as regulations and requirements have increased, Cesta points out. "When people look at it from the outside, it looks fairly simple. Many people don't understand the relationship between finances and case management. If the hospital doesn't give the case management department the





money it needs to function well, it's shooting itself in the foot," she says.

Cesta is a firm advocate of an integrated case management model, which she says typically produces the best outcomes and is more user-friendly to physicians and staff.

The problem with integrated job functions is that in many hospitals, the caseloads have not been adjusted, she adds.

Not enough time in the day

"When role functions increase, caseloads should get lower. If you do a time and motion study and look at how long it takes to accomplish all the tasks the case managers are expected to do, you can easily see that there's not enough time in the day," she says.

Case management departments need to have floating staff who can take over the caseload when someone is absent, rather than spreading out the cases among the regular staff already struggling with a caseload of their own.

"If you double someone's caseload, they become useless. Case management departments should have a provision in their budget for floating staff," Cesta says.

A change in title only

When she speaks at conferences, Cesta often asks her audiences to raise their hands if they were a utilization review nurse on Friday and a case manager on Monday.

"It's not uncommon. The titles change and nothing else changes. It was a problem 10 years ago, and it's still happening. It's a product of administrators who don't understand case management," she says.

Case managers need an advocate, someone who can educate hospital leadership about their value to the organization, Cesta says.

Case management departments often face budget cuts because they're not revenue-producing departments and the organization's financial people don't recognize their value, Simmons adds.

That's why she makes it a point to produce a monthly report for her hospital's executive team detailing what the case managers do and tying a dollar figure to their accomplishments.

Tracking outcomes

She has compiled data on denials, length of stay, and case mix index before the case management department was started four years ago and compares it to current data.

"We're able to show improved reimbursement

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based on documentation improvement and to track days we saved by intervening and moving patients out of the system," she says.

As a result, Simmons has been able to pay competitive salaries and offer flexible hours to retain her experienced staff.

Case management roles are changing dramatically, reports **Jan McNeilly**, RN,CPHQ, CPHE, principal for clinical advisor services at Premier, Inc. hospital alliance, a San Diego-based hospital purchasing group.

Roles are expanding

"Case managers are no longer concentrating on discharge planning and utilization review. They've taken on more responsibility, including being involved in what's going on clinically with the patients, coordinating care, and making sure that documentation is correct," she says.

Many of the facilities that contract with Premier, Inc. have increased their case management departments, she says.

"There's a huge focus on length of stay and the types of beds that patients are in while they're in the hospital. The case managers are making sure the patient is always at the right level of care," she says.

Case managers are going to be needed more than ever as the health care consumer, whether it's an individual or a corporation, becomes more aware of outcomes and cost-effective care, Simmons says.

"Case managers are going to be the driving force in improving outcomes, and they need to sell themselves to the administration that way," she adds. ■