

Case Management

ADVISOR™

Covering Case Management Across The Entire Care Continuum



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Managing pain takes a partnership between patient and case manager

Treat pain like any other chronic condition

An estimated 50 million Americans — some of them your patients — live with chronic pain caused by disease, disorder, or accident, according to the American Academy of Pain Management.

Chronic pain represents a major health care problem and affects every aspect of the lives of people with pain. Consider these statistics from a patient survey recently released by the American Pain Foundation:

- Six out of 10 patients reported experiencing breakthrough pain at least once daily, severely impacting their quality of life.
- More than half of those surveyed felt they had little or no control over their pain.
- Nearly 70% said their pain has a great deal of impact on their work and more than half said pain has put a strain on their relationships with family and friends. Half have lost a job due to chronic pain.
- More than three-quarters of chronic pain patients reported being depressed while 70% said they have trouble concentrating and 86% reported an inability to sleep well.

“Chronic pain, like any other chronic disease, has an impact on all aspects of a person’s life. When people have a set of symptoms that can’t be cured, it affects them physically, emotionally, and socially,” says **Dennis C. Turk**, PhD, John and Emma Bonica professor of anesthesiology and pain research at the University of Washington in Seattle. Turk is past president of the American Pain Society.

Chronic pain management should be a partnership between the patient and the case manager, Turk says. “Since there is not a cure for chronic pain, self-management becomes very important. People have to work with their health care providers to find a way to manage their pain,” he adds.

The person with pain has to become part of the treatment team. Unless they have an active role, it doesn’t matter what else health care

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providers do, adds **Penney Cowan**, executive director of the American Chronic Pain Association, based in Rocklin, CA.

Case managers should help their clients understand the solution to their pain involves much more than just a medical one, Cowan says.

"There's not just a medical solution to diabetes. People with diabetes have to be responsible for their diet, medication, monitoring their blood sugar levels. We empower them to control their disease and give them the tools for doing so," she says.

The first step in helping people learn to manage their pain is to believe that their pain is real, Cowan suggests.

Validating the patient

"Pain is invisible and there's no way to physically document the pain someone is having. The only way case managers can help people live with it is to validate them and believe that they have the pain," she says.

Many patients are concerned that people don't believe their pain is real, since there are no objective signs that characterize pain, Turk asserts. He points out that 86% of people with back pain and 98% of people with chronic headaches exhibit no physical pathology to indicate pain.

People with pain feel so strongly about convincing health care providers that their pain is real that the pain is all they can talk about, Cowan adds. "This represents their desperation to get people to believe what they are saying about their pain," she says.

Concentrate on the entire person and not just the pain, Cowan suggests.

"Pain is not a person's whole identity. It's a small piece of who they are. That's why we prefer to call them people with pain, rather than chronic pain patients," Cowan says.

Take time to listen to your clients with chronic pain, Turk advises. "One of the things that people with chronic pain tell us most often is that clinicians and case managers don't really listen to them. They just start focusing on what to do and the body parts and not the person," he says.

Listen to your patient's worries and concerns, Turk advises. Find out what patients are worried about, what areas of their lives are impacted by pain, and work with the patients to come up with solutions. Many people with chronic pain are concerned that it's going to get worse and they'll become disabled, bedridden, and totally dependent.

Find out what their symptoms are, what their greatest problems are, and what will represent an acceptable improvement to them. For instance, if a patient indicates on a scale of one to 10 that his pain is an eight, find out what level he is willing to tolerate.

Managing, not curing, pain

For many people, additional medical treatment won't eliminate the pain, Cowan points out. That's why people with pain need to understand that a chronic pain program is not about a complete cure. It's about learning to manage the pain and learning to live with it, she adds.

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Editorial Questions

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“People with pain often look to medication to give them that quick fix. They have unrealistic expectations. Those issues have to be addressed first. They have to understand that their pain is not an acute condition,” she says.

Cowan likens treating chronic pain to fixing a car with four flat tires. “If you give a person with pain appropriate medication, it’s like putting air in one of their tires. Health care providers and the person with pain need to work as a team to identify how to fill those other three tires,” she says.

Many of the treatments for chronic pain have side effects, particularly the more invasive treatments, such as surgery, Turk points out. “Any surgery can lead to a different set of problems. Many medications have side effects as well,” he says.

Encourage your patients to start with exercise and put off the more aggressive types of treatment unless there is a good medical reason, such as a tumor or a fracture.

“People have to accept the fact that they have a chronic condition that won’t be cured. There are a lot of options for improving the symptoms but they need to understand that one more surgery or one more nerve block will not eliminate all pain,” he says.

People with pain need to understand the responsibility of the medical community and their own responsibility in controlling their pain, Cowan says.

Non-drug solutions

“It takes a team, not just a pill,” she says.

Solutions may include physical therapy, counseling, occupational counseling, stress management, or a variety of techniques, she says.

Help people with chronic pain break down their goals into manageable steps so people don’t set themselves up to fail, Cowan says. For instance, stretching is helpful for people with chronic pain but if someone gets a workbook with 18 sketches and tries to do 10 repetitions of each exercise, they’re going to hurt the next day.

“We recommend that the first day, they do one leg lift and work up gradually. The whole point is to take it gradually,” she says.

People with chronic pain tend to focus on what they can’t do any more. Case managers can help them focus on what they can do, Cowan says. Encourage people with pain to understand that they can do things but they have to do it within their own limits.

“Pain is never consistent. On good days, people with pain may overdo it and wear themselves out completely, which increases their level of pain. Then they may stay sedentary on their good days,” she adds.

Recognize the emotional aspect of people with chronic pain but be cautious about immediately referring them for counseling, Cowan suggests.

“Many people with pain hear that they have to live with the pain and they become depressed but they’re not clinically depressed.

“Case managers shouldn’t start by referring them for counseling because they will become defensive and feel like they have to defend their pain,” she adds.

“I get calls all the time from people with pain who say that their health care providers think it’s all in their head. If they have to defend their pain, it will reduce the effectiveness of any treatment,” she adds.

Case managers should direct their patients to resources that can help them manage pain day by day. “Health care providers can’t do that. People with pain need information on support groups, workbooks, and other resources to help them,” Cowan says.

Help patients communicate with doctors

Help your patients prepare for doctor visits. “Most people don’t know how to communicate with their doctors. Case management coaching on the types of questions to ask and how to ask them will be a big help,” she says.

She suggests the pain log tool on her organization’s web site, a two-page instrument that patients can use to measure pain, stress, activity level, exercise, mood, sleep, and appetite:

<http://www.theacpa.org/documents/8%205x11%20Pain%20Log%202-8-06.pdf>.

RESOURCES

For more information on chronic pain:

- American Chronic Pain Foundation: www.theacpa.org
- American Pain Foundation: www.painfoundation.org
- American Pain Society: www.ampainsoc.org
- National Pain Foundation: www.NationalPainFoundation.org
- National Chronic Pain Outreach Association: www.chronicpain.org
- National Institute of Health: http://www.ninds.nih.gov/disorders/chronic_pain/chronic_pain.htm

The doctor can immediately get a total picture of the patient and can compare the patient's results on previous tools.

Be aware that family members and significant others can be helpful but can also undermine the patient's progress, Turk says. Find out about the patient's support system. Know what support is available and how family and friends are helping or hindering the patient's progress.

Turk tells of a patient whose wife was so afraid he was going to overdo it, that she interfered with his exercise regimen. "She literally prevented the patient from engaging in the activities we had worked to develop. People can be non-supportive, even when they intend to be helpful. Patients with chronic pain do have limits and may need assistance but they also need independence," he says.

Health care providers can work with families to help them be supportive but at the same time, help them understand that giving patients too much help can prevent them from making progress, he adds.

Pain program includes cognitive, physical therapy

Multidisciplinary approach includes classroom

A multidisciplinary pain management program with a strong case management focus helps members of Kaiser Permanente with moderate to severe levels of pain receive effective care and avoid using treatments that don't work.

"The goal of the program is to help our members to live as full and productive a life as they can in spite of their chronic pain condition. We want to make sure they don't end up using just one technique, such as medication, but use a variety of strategies to manage their pain," says **Andrew Bertagnolli**, PhD, care management consultant with Kaiser Permanente's Care Management Institute in Oakland, CA.

The program includes an intensive 10-week program of cognitive behavioral therapy and physical therapy followed by individual contacts by care case managers who work with members for about a year, acting as health coaches and helping members follow care plans.

"We treat chronic pain as a chronic condition, like diabetes or congestive heart failure, and

work with the member to develop strategies that can help them learn to self-manage their pain," Bertagnolli says.

Win-win situation

The program is a win-win situation for Kaiser Permanente and its members, Bertagnolli points out.

"The literature shows that members with chronic unmanaged pain are high utilizers of health care services. These people's lives are topsy-turvy because of the pain. That often drives them to come in to the medical centers for service. By learning to manage their pain effectively, members feel better, improve their functional status, and cut down on their use of the health care system," he says.

Kaiser developed the program in 2000 in response to employers who expressed concern about increases in absenteeism due to chronic pain and the health plan's goal of ensuring that members with chronic pain receive treatment based on scientific evidence.

A work group of physicians, physical therapists, psychologists, pharmacists, nurses, and osteopaths with expertise in chronic pain developed clinical practice guidelines that emphasize a multidisciplinary approach to treatment.

The program was distributed to medical directors in all Kaiser regions. The regions have tailored the program to meet the needs of their members.

"The program is being used in many of the Kaiser regions but not uniformly. The program is being used most frequently in Northern California, Southern California, the Northwest region, and the Mid-Atlantic states region," Bertagnolli says.

The majority of members eligible for the program are identified through referrals from their primary care physicians. In addition, when claims data identify members who are heavy users of health care services that may indicate chronic pain, they contact the member's physician to determine if the member could benefit from the chronic pain program. The majority of the members in the program have back pain diagnoses. Other conditions include fibromyalgia, nerve disorders such as diabetic neuropathy, chronic headaches, neck pain, shoulder pain, and other painful bone and muscle conditions, he says.

"In addition to chronic pain, these members are also experiencing moderate to severe levels of impacted functional status. Not only do they

have severe pain but their lives are a wreck. They're not working, they have problems with activities of daily living, and their social lives are in chaos," Bertagnolli says.

When members are identified for the program, they are contacted by a nurse case manager who tells them about the program and lets them know that their physician believes the program would benefit them.

Evaluating program participants

Program participants are evaluated by the chronic pain team that includes a physician, a psychologist, and a physical therapist, all trained in chronic pain management. The team develops an individual care plan for reducing pain, which is shared with the member's primary care physician. During the initial evaluation, members are assigned to either the moderate or the high intensive program, based on their pain and dysfunction.

The more complicated, dysfunctional patients are in the more intensive program and may be managed by a psychologist following the 10-week classroom session. Those at lower risk may have mild mood symptoms or problems with relationships and are managed by a care case manager.

The team may suggest strategies that include physical therapy, diet, medications, walking and stretching, stress management techniques, and psychotherapy for depression and anxiety, depending on the needs of the individual member.

The intensive treatment phase of the program is a group intervention led by a psychologist and a physical therapist at Kaiser medical centers throughout the regions.

The program includes cognitive behavior therapy led by the psychologist and sessions with physical therapists who help the members learn exercises and body mechanics that can help alleviate their pain.

The team works with members to help them accept their pain as a chronic condition.

"Most people who experience chronic pain believe that it is an acute pain problem that will go away with the right medication and right treatment. There is no magic bullet for chronic pain. It's a condition you manage not only by medication, but a variety of strategies," he says.

During the 10-week program, the case managers help participants overcome barriers to attending the sessions, such as child care or lack

of transportation, and may help them adjust their pain medication using protocols under the direction of the chronic pain physician.

"During the intensive phase of the program, the case manager's role is lessened, unless that patient is being titrated on medication," he says.

An individualized program may include psychology, physical therapy, medication, and complementary medicine techniques such as acupuncture and acupressure.

"Chronic pain is not an easy problem to solve because it affects so many aspects of life, including recreation, occupations, and relationships. When people have severe chronic pain, they become depressed and need help in managing their moods as well as their pain," he says.

When the intensive phase ends, the team meets again and develops a follow-up plan for each member. The plan includes the strategies the member should follow and the estimated frequency of the case management contacts.

After the program, the case managers contact the members regularly by phone to help them learn how to self-manage their pain.

"Research shows that the primary treatment for chronic pain is learning to self-manage the condition and to use the health care system in a consultative role. This program helps empower the members to do just that," Bertagnolli says.

The frequency with which the care case manager calls the member depends on the individual's needs. It may be as frequently as every two weeks or as little as every two months.

"If the member is having a problem, the case managers can identify it earlier, rather than later, and ensure that the member gets the care he needs," Bertagnolli says.

The case managers help the members stick with their treatment plan, which may involve stress management, diet and exercise, and taking medications as directed, and assist members in finding support groups in the community.

"The case managers encourage them to use stress management and mood management techniques as well as other behavioral strategies. If the patient seems to be slipping, the case manager can refer him or her to the psychologist or the physical therapist for reinforcement," he says.

One of the areas the case managers concentrate on is diet, Bertagnolli says.

"Many of the members are overweight and the evidence shows that if they lose weight, their lower back, hip, or knee pain gets better. Participants who have migraine headaches need to learn to identify

what foods can trigger a headache,” he says.

Case managers follow the members for up to a year, suggesting pain management techniques and providing referrals for acupuncture, psychiatric care, and other services.

If a member in the program pops up on the list of high utilizers of health care services, the case manager is alerted and calls the member to find out what’s going on.

“Sometimes it may be a problem with the primary care physician. We want to hear about it as soon as possible so the physician on the chronic team can work with the primary care physician to modify the treatment plan,” he says. ■

Back care program helps to keep pain under control

94% of enrollees are ‘very satisfied’

After being enrolled in MVP Health Care’s back care program for a year, the percentage of participants reporting that their back pain did not interfere with their work increased from 10.9% to 22.9%.

The percentage of program participants who reported their back pain as “none,” “very mild,” or “mild” increased from 28.2% on enrollment to 44.3% a year later. Nearly 94% of members enrolled reported being “very satisfied” with the program one year later.

MVP Health Care’s Back Care program takes a multi-tiered approach to helping members learn to manage their pain. The program includes educational materials, health coaching by registered nurses with education on back pain management techniques, and support for health care professionals who treat patients with back pain.

The Schenectady, NY, health plan established its back care program in 2002 in response to the increase of unproven, high-cost treatments for low back pain among members.

“Our utilization management review showed that members were getting procedures that were not effective, such as epidurals or laminectomies. We felt that the best way to help our members deal with their low back pain was to promote a conservative approach,” says **Jana Altieri**, RN, MS, quality improvement program manager.

The health plan modeled the low back pain program after its asthma, diabetes, and heart dis-

ease programs, Altieri says.

Members who have been diagnosed with low back pain and have had at least two claims at least 10 weeks apart are eligible for the program. They are identified through claims data, referrals by physicians and MVP staff members, and self referrals.

The health plan mails information about the back care program to all members identified with low back pain and asked them to return a health risk assessment that measures functional health and well-being.

The survey, an adaptation of the SF-36 Health Survey, asks members to rate their health on an analogue scale in categories that include physical functioning, physical limitations, bodily pain, and general health. It includes questions about the severity of back pain; how it affects physical activity, emotional well-being, energy, and fatigue levels; and how members perceive their health.

Members are stratified into risk levels based on the health risk assessment and other factors. The outreach portion of the program focuses on people who are high risk and report a high level of pain, Altieri says.

Members identified as being high risk receive a call from the health plan’s outreach staff, describing the program. Those members who are at high risk are assigned to a registered nurse, trained as a health coach for back pain. The nurses go over members’ medical history with them and identify any psycho-social issues. They work with the members to set goals and come up with the steps they should take to reach those goals.

“People have chronic pain because of so many different situations. It may be wear and tear over a long period of time or an injury. There’s no one solution to alleviate the pain so the nurses examine all the possibilities,” she says.

The nurses assess members’ needs, such as losing weight, stretching, or modifying work environments, and help them identify goals and come up with strategies to meet the goals.

“One-on-one support is an important part of the program. The nurses work with the members to set individual and realistic goals,” Altieri says.

The health coaches encourage members to take “baby steps” in setting their goals, rather than setting themselves up for failure, Altieri says.

“They help them overcome barriers to achieving their goal, work on problem-solving skills, and help them learn to self-manage their condition,” she says.

For instance, a member’s goal may be to be

able to pick up her grandchild.

“The nurse works with the member on losing weight, exercising, stress reduction — whatever is needed to help her reduce the pain and improve her functionality so she can do that in the end,” Altieri says.

The nurses ask the members about which remedies they have tried including physical therapy, ‘chiropractic care’, home exercise on a daily basis, and using proper lifting techniques, heat, ice, and other modalities.

“We encourage members to try all of that first and if it doesn’t work and they’re still in pain and functionally impaired, maybe an epidural is the next step,” she says.

The nurses call the members at regular intervals for up to a year, based on their needs. Most of the members are in the program for four or five months.

“The frequency depends on the individual. In the beginning, the nurse may call a member weekly, then monthly, and then just occasionally,” she says.

Members are asked to repeat the health risk assessment upon discharge from the program, six months later, and one year later.

The health plan sends members a biannual newsletter with information on effective care for back pain. Members receive a back care workbook with information on strategies to alleviate back pain.

The health plan sends information to primary care physicians about members who are eligible for the high-risk portion of the program but did not agree to participate so the physicians can encourage them to enroll.

Once a year, MVP sends physicians who treat a high volume of MVP members a CD that includes clinical practice guidelines for treating back pain and other information. ■

Study shows best practices do improve outcomes

Randomized study shows where improvement needed

One of the most challenging issues for quality managers is demonstrating that best QI practices can actually improve outcomes. Demonstrating such success requires a good deal of time and resources. In light of this challenge, the results of a

new study published in *JAMA* should be good news, indeed.

The article, based on data from the Global Registry of Acute Coronary Events (GRACE) study, which has collected data from 44,372 patients treated at 113 hospitals in 14 countries, shows a correlation between a period during which hospitals increased use of certain drugs, tests, and procedures that have been proved to help reduce the immediate and long-term impact of acute heart problems, and a significant drop in the rate of heart failure and death. People who suffer a heart attack or severe chest pain today are much less likely to die or to experience long-lasting effects than their counterparts even a few years ago, according to the study.¹

All of the patients studied had suffered either an ST-elevated myocardial infarction (STEMI) or had acute coronary syndrome (ACS), which includes non-STEMI heart attack and unstable angina. Between 1999 and 2006, the use of drugs such as aspirin, statins, glycoprotein IIb/IIIa inhibitors, clopidogrel and heparin, and ACE inhibitors increased markedly. At the same time, the use of angiography and angioplasty as an emergency or secondary treatment to reopen blockages increased by more than 30% in STEMI patients and about 20% in ACS patients.

“I think the most significant finding was the magnitude of improvement in both inpatient and six-month outcomes that reflect the global effort to provide more rapid reperfusion for ST-elevation MI and a steady migration to using acute angioplasty as an approved method to open occluded arteries, and the remarkable impact on inpatient heart failure and stroke that was maintained after six months by getting patients on evidence-based therapies after leaving the hospital,” says **Kim Eagle**, MD, FACC, a co-author of the paper and co-chair of the publication committee for GRACE, and director of the University of Michigan Cardiovascular Center in Ann Arbor.

A ‘remarkable transformation’

Eagle notes these findings mirror a recent progression toward greater use of evidence-based practices. “Professional societies began creating guidelines 30 years ago, and 20 years ago we started having important randomized trials that suggested improved outcomes, but as recently as

15 years ago, studies said doctors were not using their own guidelines," he notes. "In the last 10 years we've seen a multifaceted effort at trying to make sure these key therapies are available to every patient we treat."

Today, he continues, "we are being asked to show this through core measures, and, in some cases, it affects the way reimbursements are parceled out. This reflects quite a remarkable transformation that we're in."

While he was careful about calling this paper one of the first studies to show that following best practices leads to better outcomes, Eagle offered that: "This is one of the largest studies [of its kind] in the world. This is observational, taking the average patient who presented to one of 115 hospitals [with one of these conditions] and a six-month follow-up. It suggests if we do a good job at the point of discharge, we will do better downstream as well, and that is very gratifying."

Eagle says the study also underscores that in the early treatment of ACS "the evidence that reperfusion with balloon whenever available is beneficial is compelling. And this study shows that in real-world experience, the benefit may even exceed what we saw in the trials. Second, we cannot underestimate the additional benefit on other outcomes, such as heart failure and stroke."

Making failure impossible

Despite the encouraging results, there were also disappointments. For example, the percentage of patients receiving reperfusion therapy has not increased significantly over time. Eagle also notes that only 85% of STEMI patients and 83% of ACS patients in the study received a statin in 2006, when virtually all such patients should receive the cholesterol-lowering drug.

So, for example, at the point of discharge the University of Michigan has created a system where every quality measure is gone over and explained. "For example, if the patient is not on blood pressure medicine, we have documented why they are not," Eagle explains.

Tracking the patient's experience is also important, he continues. "For example, if a patient's heart rate is 50 when they are admitted, they would not get a beta-blocker; but when they are discharged and it is 80, they are now eligible. However, this could potentially get omitted unless there is a system of review."

There could be simple human errors, such as forgetting to tell a patient they need to stay on

aspirin or not writing a prescription because it can be purchased over the counter. "Those kinds of simple little omissions can have a big impact when you are treating a large population," Eagle notes.

The program at the University of Michigan starts with standardized orders, key early strategies, and at the point of discharge, a document called a contract that both the nurse and the patient sign. "It basically goes over key lifestyle goals, key pharmacological drug goals, and tries to ensure a clear follow-up plan that includes the patient knowing what to do if they get recurrent symptoms," Eagle explains.

When the chart is coded, the discharge coders also review the notes and if they pick something up, the doctor is immediately notified and can call the patient to correct the information.

"So, we have three levels of correction," says Eagle. "We've shown when we use this layered redundancy we substantially improve quality indicators to almost 100% of patients, and we have a significant impact on six-month recurrent MI and death." The three keys to success, he continues, are clear quality goals, a simple way to track performance, and a feedback loop to make sure they are adhered to. "We send a quality measures report card to our doctors and nurses every month," he reports. "The future of quality is to guarantee, rather than say we are trying."

A few years ago, he notes, "We stopped asking the question, 'How can we get better?' We started asking, 'How can we make sure we never miss?'"

[For more information, contact Kim Eagle, MD, FACC, Director, University of Michigan Cardiovascular Center, Ann Arbor, MI. Phone: (734) 936-5275.]

Reference

1. Foxx KAA, Steg PG, Eagle KA, Goodman SG, et al. Decline in Rates of Death and Heart Failure in Acute Coronary Syndromes, 1999-2006. *JAMA* 2007; 297:1,892-1,900. ■

Light duty gaining acceptance for workers

Tailoring light duty to job, employee aids success

When an employee at your facility reports back after an injury or illness with a physi-

cian's order for "light duty" in hand, is the prescription a guide to what the employee can do, what he or she can't do, or a chance to look at the employee's ability to contribute in a new way?

Denise Zoe Gillen, RN, BSN, MBA, COHN-S/CM, practice leader in integrated health and productivity management for Mendham, NJ-based Risk Navigation Group, subscribes to the last approach.

"Now we oftentimes use 'transitional' or 'alternate duty' instead of 'light duty,' because to say they are assigned to 'transitional duty' means they are in transition — that what they are doing is not 'light' work, but is an assignment made so they don't have to do tasks they're not physically capable of doing," she says.

When the employee is a nurse, Gillen says she first looks at the nurse's regular job, to see if it can be broken down into components and a new, less physically demanding version created from the individual parts. "If you break down the tasks of their job, then you can say, 'they can maybe only lift 10 to 20% of what they ordinarily can, but they can do all the other components of their job,'" Gillen explains.

That type of change means a floor nurse's ability to do her regular duties is going to be much more affected by limitations on lifting than a nurse who works in the neonatal intensive care unit (NICU), for example. "You always have to consider the employer and the setting when an employee returns on light duty," she says. "So even if a nurse has limits on what they can lift, a NICU nurse is not going to be lifting 50 or 100 pounds," and so limits on lifting would not necessarily be a factor in whether or not that nurse could return to his or her original assignment.

What's 'light' depends on job

The scenario Gillen describes — an employee returning to work to his or her same job, but doing only the parts of it that he or she is capable of — is what the U.S. Department of Labor refers to as "limited duty" in its workers' compensation laws. Many employers use the terms "light duty," "limited duty," "modified duty," or "transitional duty" interchangeably, while others apply one — usually limited duty — to employees returning from a job-related injury or illness, and another — light duty — to employees returning from a non-work-related condition.

The Department of Labor says limited duty includes responsibilities that are part of an

employee's regular position, that meet the employee's work capabilities as determined by his or her doctor.

But the real meaning of light or limited duty is determined by the employee's regular job. What is light duty for one person might be heavy work for another, depending on the job, setting, and physical limitations, Gillen points out. "Depending on the employer, it's a good idea to develop job tasks by position ahead of time, so if you're in health care, for example, break down the job tasks of your nurses by where they work and what their duties are," she says.

Judy Van Houten, RN, COHN-S, CCM, manager of occupational medicine services at Glendale (CA) Adventist Medical Center, says the occupational health nurse "has to wear two hats" when working with employees returning on light duty. "I'm looking at it from a clinical point of view," she explains. "I have to give the employer or the supervisor the restrictions, and at the same time tell the employee what he or she can or can't do."

The light-duty prescription can be taken as a positive, as in "this is what this employee CAN do," but most often is taken as its negative meaning: "This is what this employee CANNOT do," she says.

Being comfortable with light duty and understanding what it means can be different things. Often, supervisors — or the employees themselves -- might have incorrect ideas about what light duty is and is not. "There are often differing perceptions of what the employee's restrictions and limitations are, and there's often a difference between what the restricted person thinks they can do or not do, what the job demands are, and what the employer's expectations are," says Van Houten.

Gillen says the occupational health nurse or case manager can help clarify those distinctions. "The case manager or occupational health nurse's job is to explain the role of the nurse as well as what everything means and to let the employee know that when the doctor puts you on light duty, it doesn't mean you can't work, but it does mean we don't want you to do too much and thereby limit your recovery time," says Gillen. The idea is to help the employee not only become functional at work again, but also to be functional at home, she adds.

Typically at Glendale Adventist, Van Houten says, nurses who return to work on limited duty are placed in a different area of the hospital until they are ready to go back to their regular jobs. "The

method to the madness is in a couple of things," she explains. "If they are in a different department and not their home department, the employee is not burdened with the guilt of feeling like they are not doing their jobs and are not a member of the team." The second part is that it becomes a positive for the department where the employee is temporarily assigned, because they get an extra set of hands for free, Van Houten says. Pay for light duty comes out of a separate cost center for modified duty and transitional work, so neither department carries the expense of paying the employee's salary.

Finally, while it makes financial sense in most cases for the employer to find light duty for an injured worker to return to, and occupational health experts say recovery is hastened when workers can get back to work, providing light duty to employees is not something employers are required to do.

But light duty doesn't have to feel like a bad thing to the employer or employee. "Light duty has gained a lot more acceptance from the supervisors' and employers' points of view," Van Houten says. "There are fewer and fewer employers who, when they get a [light duty note] from the doctor, throw up their hands and say to the employee, 'Don't come back until you're 100%! More of them are OK with limited duty, and more employees are OK with doing limited duty.'" ■

Staph infection numbers moving in wrong direction

Increasing at 7% annually in hospitals

The numbers are in and they aren't good. Data presented recently in Baltimore at the annual meeting of the Society for Healthcare Epidemiology of America document an inexorable increase in staph infections in the nation's hospitals.

"I don't think it is any surprise that the total number of staph infections went up," says **Gary Noskin**, MD, lead author of the study and a health care epidemiologist at Northwestern Memorial Hospital in Chicago. "But it's hard to know what that means. Does it mean there were more staph infections because we are taking care of sicker and sicker patients? We are able to do surgical procedures [and medical interventions] on patients who are a lot older than [those undergoing the same

procedures] 10 to 15 years ago. As the population ages, it may be a reflection of that. It may be a reflection that there are more people at risk. Obviously, dialysis patients, injection drug users, people with diabetes are at increased risk for staph infections."

Noskin and co-researchers analyzed more than 45 million hospital discharge records and found that from 1998 to 2003, the prevalence of *S. aureus* infection among all patients increased at an annual rate of 7.1%.¹ The problem grew even faster among surgical patients, for whom the rate of staph infections rose 7.9% each year for all surgical stays and 9.3% each year for orthopedic patients.

The data were gleaned from the Nationwide Inpatient Sample and billing and discharge data reflecting about 20% of hospitalizations nationally that are submitted to the Agency for Healthcare Research and Quality (AHRQ). However, the data set does not enable researchers to discern whether the infection was caused by drug-susceptible or resistant staph strains, though the CDC projects that MRSA now is causing almost two-thirds of all staph infections.

Indeed, the primary sources to estimate the prevalence of MRSA have been discharge data and surveillance data from Centers for Disease Control and Prevention sentinel hospitals. However, critics charge that the CDC sentinel surveillance is biased somewhat toward large teaching hospitals and that MRSA is likely underreported in discharge data. The Association for Professionals in Infection Control and Epidemiology (APIC) is conducting a national prevalence survey that was expected to be presented at the 2007 APIC meeting in San Jose, CA. It will be interesting to compare those results to data presented at SHEA, where Noskin and colleagues also offered an assessment of the economic impact of staph infections.

Using the same data set, they found that from 1998 to 2003 the economic burden among all *Staph aureus*-related inpatient stays increased from \$8.7 billion to \$14.5 billion, an annual increase of 11.9%.² "These findings clearly demonstrate the considerable economic implications of *Staph aureus* infections for hospitals nationwide," Noskin says. "It suggests that there could be large cost savings associated with aggressive efforts to prevent patients from becoming infected with these bacteria. We were able to look at changes compared to patients without staph infections and then look at things like length of stay and comorbidities. The

biggest driver of costs in health care is length of stay in the hospital.”

References

1. Noskin G, Rubin R, Schentag J, et al. Trends in the prevalence rate of *S. aureus* infection in U.S. hospitals, 1998-2003. Abstract 132. Presented at the Society for Healthcare Epidemiology of America. Baltimore; April 14 -17, 2007.

2. Noskin G, Rubin R, Schentag J, et al. Trends in the economic burden of *S. aureus* infections in U.S. hospitals, 1998-2003. Abstract 64. Presented at the Society for Healthcare Epidemiology of America. Baltimore; April 14 -17, 2007. ■

AHRQ: Good news, bad news on gender discrepancies

Although there are signs of improvement in some conditions, differences in the quality of health care provided to men and women continue to persist, according to the latest News and Numbers from the Agency for Healthcare Research and Quality (AHRQ).

The good news is that:

- In 2004, about as many women with Medicare (85%) received recommended care in the hospital after a heart attack as male Medicare patients (86%). As recently as 2002, only 79% of female Medicare patients received the recommended treatment after a heart attack, compared to 81% of male Medicare patients. Heart disease is the leading cause of death among both women and men.

- Women were more likely than men to have a usual source of ongoing health care in 2004 (90% compared with 83%). Across all income level groups and for most racial and ethnic groups, women reported having a usual source of ongoing care more often than men. A usual source of care is associated with lower costs and improved health outcomes.

However, there is bad news:

- Women were more likely than men to be hos-

pitalized for high blood pressure in 2003 — 56 vs. 38 per 100,000 population. Hospitalization for high blood pressure can usually be avoided if patients have good quality primary care.

- Women age 50 and older were less likely than men to receive recommended colorectal cancer screening — 50% percent compared with 54% percent in 2003.

- There are disparities among women by race and ethnicity. For example, although only half of all white women are screened for colorectal cancer at age 50 or older, among Hispanic and black women the rates are even lower — 38% and 44%, respectively.

- Only 71% percent of American Indian-Alaska Native, 76% of black, and about 78% of Hispanic women start prenatal care in the first three months of pregnancy, compared with 86% of white women.

These data were derived from the “2006 National Healthcare Quality Report” and the “2006 National Healthcare Disparities Report,” which measure the quality of health care across America in four areas — effectiveness of health care, patient safety, timeliness of care, and patient centeredness. ■

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COMING IN FUTURE MONTHS

■ Strategies for managing the care of elderly patients

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■ How workplace wellness can pay off for health plans

CE questions

1. Which of the following does the American Pain Foundation report:
A. Six out of 10 patients reported experiencing breakthrough pain at least once daily, severely impacting their quality of life.
B. More than half of those surveyed felt they had little or no control over their pain.
C. Nearly 70% said their pain has a great deal of impact on their work and more than half say pain has put a strain on their relationships with family and friends.
D. All of the above
2. How many weeks is Kaiser Permanente's multidisciplinary pain management program?
A. four weeks
B. six weeks
C. 10 weeks
D. 14 weeks
3. Nearly 63% of members enrolled in MVP Health Care's back program reported being "very satisfied" with the program one year later.
A. True
B. False
4. After analyzing more than 45 million hospital discharge records the *S. aureus* infection among all patients increased at what rate annually?
A. 7.1
B. 8.1
C. 9.1
D. 6.3

Answers: 1.D; 2.C; 3.B; 4.A.

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. ■

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