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INSIDE

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Do you want to dramatically improve productivity? Offer depression outreach

(Editor's Note: This is part one of a two-part series on behavioral health issues. This month, we cover new research showing the link between depression interventions and productivity. Next month, we'll report on a growing trend toward integrating behavioral health and medical care.)

If an employee is depressed, that person may come to work every day, but how productive are they? Not very, says new research that shows a workplace program to identify depression and promote effective treatment significantly improves employee health and productivity.[1]

Still, few employers have implemented such programs, probably because they have decided it's unlikely to be cost-effective, says study co-author **Ronald C. Kessler**, PhD, a professor at Harvard Medical School's Department of Health Care Policy in Boston.

During Web-based or telephone screening, 604 employees from 16 large employers from a wide variety of industries were identified with clinically significant depression. Half were given an intervention with telephone support from a care manager and their choice of telephone psychotherapy, in-person psychotherapy, or antidepressant medication. The other half were given only feedback about their screening results and advised to seek care from their usual provider.

After one year, the employees in the intervention group were 40% more

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Programs to identify and treat depression have a significant impact on employee health and productivity, according to recent research, but many employers have not implemented these programs. Key findings:

- Employees with depression were offered telephone psychotherapy, in-person psychotherapy or antidepressants. Cost was $100 to $400 per person.
- Employees who received the intervention worked an average of two hours more per week, worth $1,800 per person per year.
- Employee assistance programs decreased the duration of short-term disability claims by about two weeks.

likely to have recovered from their depression, 70% more likely to stay employed, and worked an average of two hours more per week. The extra hours alone are worth $1,800 per employee per year, noted the researchers, which is much more than the $100 to $400 per person cost of the intervention.

"Our results show definitively something that we already suspected but never before rigorously documented: that high quality management of depressed workers can have a positive [return on investment] for employers," says Kessler. "Our hope is that employers will recognize the human capital investment opportunity in our findings and will respond by expanding their depression outreach-treatment programs."

These study results send a clear message to occupational health professionals that depression screening and intervention programs are a "win-win investment," says **Philip Wang**, MD, DrPH, the study's lead author and director of the National Institute of Mental Health's Division of Services and Intervention Research in Bethesda, MD. The results are important because depression takes a hefty toll on the U.S. workplace, affecting about 6% of employees each year and costing more than $30 billion annually in lost productivity, said Kessler.

"Not only is depression associated with poor health and suffering, but lost productivity as well," says Wang. "Our trial results suggest that enhancing the care of depression can effectively mitigate these negative outcomes."

Return to work sooner

The Hartford, a Simsbury, CT-based employer and disability insurer that participated in the above study, also did its own four-year prospective study from 2002 to 2006 involving 22 businesses in various industries with total of 94,000 employees.[2] Eleven offered Employee Assistance Programs (EAP) services to their employees, and 11 did not.

The study found that EAPs decreased the duration of short-term disability claims by about two weeks. **Carol A. Harnett**, The Hartford's national practice leader for group disability and life practices, says, "We believe it is important to direct resources toward assisting employees. Stress, depression and other behavioral health conditions are prevalent, costly, and treatable."

The Hartford's study found that mental health conditions often were hidden underneath physical complaints, says Harnett. "Researchers and industry experts alike often point to behavioral health issues accompanying physical diagnoses," she says. "Our study provided substantiation to this belief, showing that 71% of employees who sought EAP services filed disability claims for physical conditions."

Also, while 33% of employees with short-term disability claims who took advantage of EAP services returned to work, only 20% returned who didn't use the services, and only 16% returned who didn't have access to EAPs.

"When we looked at the direct costs associated with decreased short-term disability claim incidence and took the cost of the EAP program into account, we found an approximate 4:1 return," says Harnett.

Historically employers have seriously underestimated the financial impact of worker depression, not only on direct medical costs, but more importantly on productivity, says **Joe Marlowe,**

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senior vice president of the health and benefits practice at Aon Consulting, a Chicago-based consulting firm specializing in employee benefits.

"We still have a long way to go before employers really appreciate the impact of depression," says Marlowe. "We know that depressed workers are absent more, are far less efficient while at work, and consume more medical services including prescription drugs."

Depression tends to be underdiagnosed, and once diagnosed, tends to be undertreated, with treatment regimens often not consistent with evidence-based medicine, since the condition is often treated by primary care physicians instead of psychiatrists, says Marlowe. "With the high levels of stress that workers are under in this country trying to balance work and family life, what we are starting to see is younger employees, who you expect to be very productive and making major contributions, with particularly high rates of depression," says Marlowe.

Don't treat "in a vacuum"

Employers are starting to realize that they can't treat depression and mental illness "in a vacuum," says Marlowe, and they are beginning to integrate this with all their other medical programs. Various vendors should exchange information to make one another more effective, he advises. For example, every employee who surfaces as a potential disability claimant should be screened for depression because that will have an impact on how quickly they come back to work, he says.

If you only consider direct medical costs of depression, you are missing the bigger picture, says Marlowe. By asking employees to complete a brief survey about medical conditions in the previous 30 days, including depression, and asking them what they perceive is the impact on absence and presenteeism, you can unearth the hidden lost productivity of depression, he says. "Usually, the results of these kinds of surveys are an eye-opener for employers," he says. "You start to see a very different picture, because the medical and drug claim data don't demonstrate the impact of depression."

He points to an analysis of medical claims of 7,797 employees performed by Dow Chemical which showed that the average employee with depression incurred under $2,000 in medical claims, but those employees reported a substantial impact on their productivity that made the actual loss more than $18,000.[3] Traditional EAP programs are "a mistake," because they are underutilized and many employees don't even know they exist, says Marlowe. Employers should be doing more outreach with individuals at risk and offering a wide range of services early, instead of waiting for employees to come to them, he says.

"We know that a depressed employee is less likely to be compliant with medical treatments and less compliant with taking their medication," says Marlowe. "By addressing the depression, you hope to improve the cooperation of the patient, which should speed recovery and reduce costs."

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If you suspect abuse of FMLA, document carefully

Walk a fine line with abusers

Legal risks and frequent abuse by employees are two problems faced by occupational health nurses (OHNs) responsible for overseeing administration of the Family and Medical Leave Act (FMLA).

"As a manager of occupational health, the most highly litigious program that I oversee is FMLA administration," says **Tamara Y. Blow**, RN, MSA, COHN-S/CM, CBM, manager of occupational health services at Richmond, VA-based Philip Morris USA.

In an effort to streamline the abuse of FMLA claims, the company has denied applications based on the interpretation of a "serious health condition," leading to Department of Labor (DOL) inquiries and lawsuits, says Blow. "We have some employees who are abusing the system, and with these high abusers, we are walking a slippery slope and fine line," says Blow. "When we try to decrease absenteeism by closing those gaps, there is a strong correlation with DOL inquiries."

FMLA programs traditionally were managed by human resources, but many companies are putting this role on the shoulders of OHNs, notes Blow. "OHNs are best positioned to manage FMLA, because we have the knowledge of disease entities and are able to determine whether the FMLA request is plausible," she says. Also, human resource professionals lack medical credibility to defend an absence that was not covered if challenged by the DOL, she adds.

Don't "just say no"

The biggest litigation risk is to "just say no" to leave requests, according to **John W. Robinson IV**, JD, a shareholder in the litigation department in the Tampa, FL, office of Fowler White Boggs Banker. Your best protection is to have written family and medical leave policies and procedures, says Robinson.

"The most important document is a form approving leave and for how long exactly," he says. "It is also important to obtain and retain medical documentation for leave."

Blow says that "excellent documentation" and partnering with the legal department has resulted in successful outcomes for all the company's FMLA inquiries.

If employees have missed more time than they were approved for, showing concern for their wellbeing will "cushion" you from being reported to the DOL, advises Blow. "Tell the employee 'I'm concerned. Your doctor says you should miss about two days a month to regulate your blood sugar, but you are missing about 15 days a month. Let's do some health coaching and teaching,'" she says.

Once intermittent unscheduled absences have been approved, the FMLA administrator cannot really challenge the absence unless there is a pattern of abuse established over two to three weeks, says Blow.

At times, employees claimed to have left voicemails or submitted paperwork requesting leave, when there was no record of this, says Blow. "Then the union would challenge us. So, we created an innovative system," she says. The employee is given a form in triplicate, with copies for the employee and supervisor, with the reason for the leave written on a copy that is put in a locked box at the clinic, which is dated and time-stamped.

"Sometime the employee may write that they are taking a leave for a headache or flu, but their FMLA was approved for back pain, so the FMLA absence request would not be accepted," says Blow. "With the stamped coupon system, we are able to say, 'this is your handwriting and not what the nurse wrote from a voicemail message, and this intermittent absence won't be covered," she says.

An employer also can perform surveillance of

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More often, occupational health nurses are responsible for overseeing administration of the Family and Medical Leave Act and must address legal risks and abuse by employees.

- Employees must be informed in writing that surveillance will be performed if a pattern of fraud is suspected.
- Have systems to provide data in the event you are challenged by the Department of Labor.
- Consult an attorney before you deny a leave request if the employee has a doctor's written approval of treatment.

SOURCES

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employees if a pattern of fraud is suspected, but the employee must be informed of this surveillance in writing, and you need to justify why a particular individual is being targeted, says Blow. "There should always be systems and policies in place that give data in case the FMLA administrator is challenged by the DOL," she says. "I always tell my staff, 'documentation beats conversation.'"

Coverage is "tricky"

Successful FMLA claims come in three basic forms. An employer flatly denies family and medical leave, denies rehire after leave, or retaliates for a leave request, says Robinson. "I suspect private lawsuits on behalf of individual employees are more prevalent than U.S. Department of Labor suits," he says.

From a legal point of view, an occupational health professional is most likely to have FMLA issues regarding a medical doctor's prescription of therapy, he says. Physicians and occupational health nurses are working together to manage medical leave, more so than they did in the past, says Robinson.

If an employee wants treatment and there is a doctor's written approval of treatment, then an occupational health professional may need to consult with an attorney before denying this request, says Robinson. "If there is no doctor's prescription of therapy, then FMLA may not apply," he adds.

Not all prescribed treatment qualifies for FMLA leave, says Robinson. Also, a employee must work for a year to qualify, and the employer must have at least 50 local employees, with some key employees exempt from FMLA leave. "FMLA provides limited unpaid leave and does not guarantee payment for treatment," says Robinson. "So FMLA coverage is a bit tricky. If in doubt, visit your lawyer." ■

Include these two things for smoking cessation

Companies report up to 30% long-term quit rates

For your smoking cessation programs to be successful, there are two things you should address, according to new research from Indiana University (IU). A non-smoking spouse and smoke-free workplace play key roles in long-term success, according to results of the IU Smoking Survey, a 27-year longitudinal study of the natural history of cigarette smoking, housed at IU Bloomington's Department of Psychological and Brain Sciences.[1]

Because most smokers cycle through multiple periods of relapse and remission, tobacco dependence is like a chronic disease and should be treated as such, says **Jon Macy**, the survey's project director.

The study's findings have important implications for occupational health professionals, says Macy. "First, the smoking status of the spouse is important. So if a worker is trying to quit smoking, he or she is more likely to have long-term success if the spouse doesn't smoke," he says.

Occupational health nurses may want to consider offering couples smoking cessation counsel-

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A non-smoking spouse and smoke free workplace are key factors in long-term success of smoking cessation, according to a new study. Two-thirds of surveyed companies offered programs to help employees quit smoking, including UPS, where 37% of 3,600 enrolled employees quit smoking after six months.
- Offer couples smoking cessation counseling.
- Advocate for a 100% smoke-free workplace.
- Give smokers a variety of options to quit.

ing in instances where both partners smoke, Macy recommends.

Individuals whose workplaces were completely smoke-free were more likely to have long-term quitting success. "The smoking policy at the workplace is important," says Macy. "Occupational health professionals should be among the leaders in advocating for 100% smoke-free workplaces."

Smokers are hot topic

Tobacco cessation has been the hot topic for the last year, says **LuAnn Heinen**, director of the Washington, DC-based Institute on the Costs and Health Effects of Obesity. Nearly two-thirds of National Business Group on Health member companies recently surveyed offer stop-smoking programs as part of their health plans, which is a sharp increase from just 10 years ago when such coverage was rare, notes Heinen.

"Spending $900 for nicotine patches and counseling support can more than offset the estimated $16,000 or more in additional lifetime medical costs that a typical smoker generates," says Heinen. These costs don't include the cost of absenteeism or reduced productivity from smoking breaks at work, she adds.

It may take a few attempts before people are able to quit smoking for good, but many companies have reported long-term quit rates of up to 30% for good smoking cessation programs with counseling support, says Heinen. "It is now generally accepted that well-conceived smoking cessation programs will more than pay for themselves over time," she says.

Smoking and tobacco use is perhaps a greater cause of death and disability than the workplace environment, says **Grace K. Paranzino**, MS, RN, CHES, FAAOHN, national clinical manager of Troy, MI-based Kelly Healthcare Resources.

Factors associated with smoking that contribute to increased costs for employers include absenteeism, accidents, increased health and life insurance costs, actual health and life insurance claims, and workers' compensation payments, says Paranzino.

Individualize programs

Offer different programs targeting individuals who want to stop smoking, those who are not yet ready to quit smoking, and smokers who have successfully quit but need support to ensure success, advises Paranzino.

As part of your program, offer pharmacotherapies and individual, telephone counseling and group counseling, she recommends.

What works for one person doesn't work for all, cautions Paranzino. "Appropriate screening is therefore necessary to assess the readiness to change and match the employee with the appropriate smoking cessation program to increase the success rate of quitting," she says.

At Atlanta-based UPS, a Tobacco Cessation program launched in February 2007 is already yielding results, reports **Judy Pirnie Smith**, RN, the company's health and productivity manager. To date,

SOURCES/RESOURCE

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The Free & Clear Quit for Life Program provides tobacco cessation services, including telephone-based, one-on-one treatment sessions with a professional quit coach, decision support and fulfillment for appropriate medications, consulting for appropriate policies including premium differentials and smokefree workplaces, and data analysis to determine an employer's return on investment. Cost averages $365 per program participant. For more information including specific pricing, contact: Free & Clear, 999 Third Ave., Suite 2100, Seattle, WA 98104. Phone: (206) 876-2100. Fax: (206) 876-2101. E-mail: miranda.wilner@freeclear.com.

more than 3,600 employees have enrolled, and 37% of those surveyed at the six-month point had quit smoking, says Smith. "We are thrilled with the initial results and hope more of our people will take advantage of this new program," she says.

When a UPS employee contacts the program, he or she is supplied with these resources, all supplied by Free & Clear, a Seattle, WA-based provider of tobacco cessation services:

- Unlimited toll-free phone counseling sessions with quit coaches for ongoing support. "The coach will help them take the necessary steps to stop smoking or eliminate tobacco use, through a program tailored to that individual," says Smith.
- integration with disease management, health plans, health assessment, wellness, and employee assistance programs;
- phone-based decision support for the type, dose, and duration of medication, as appropriate, to help with withdrawal symptoms;
- direct mail order fulfillment of nicotine replacement therapy timed with a participant's quit date;
- printed, stage-appropriate "quit guides";
- tailored motivational e-mails sent throughout the quitting process. **(For more information on Free & Clear, see resource box on p. 138.)**

In addition to counseling and screening, occupational health professionals can provide another type of support to smokers, says Paranzino. "They can provide guidance to corporations to instill a culture that is conducive to positively impacting the health and productivity of workers, thereby reducing the health burden and economic impact of smoking," she says.

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Plan to test health workers may undermine safety

In a move that runs counter to national public health guidelines and may contribute to the rise of drug-resistant pathogens, Pennsylvania has passed a state law that could lead to routinely culturing a wide variety of health care workers for methicillin-resistant *Staphylococcus aureus* (MRSA) and other multidrug-resistant organisms (MDROs).

Moreover, the Pennsylvania provision for screening health care workers in the absence of an outbreak or ongoing transmission runs directly counter to current guidelines by the Centers for Disease Control and Prevention, potentially putting every hospital in the state out of line with the prevailing standard of care. As a result, the Hospital & Healthsystem Association of Pennsylvania (HAP) is essentially telling member facilities to report they have no way to comply with such a provision because there are no established protocols to do so. Not so fast, says the state health department, which is charged with drawing up some kind of regulations to comply with the law and is in the process of doing just that. The whole thing arose from an ill-fated attempt at political compromise among lawmakers and the governor's office, which originally wanted all health care workers screened.

"These kind of [universal screening] strategies are promoted only by people who are unfamiliar with the biology of MRSA, the antimicrobials available, and the development of resistance," warns **William Schaffner**, MD, chairman of the department of preventive medicine at Vanderbilt University Medical Center in Nashville. "The less trenchant your knowledge of the subject is, the simpler it appears and the more Draconian the solutions that you find proposed. Then we in infection control find ourselves playing both defense and catch-up. We simply have to be better connected [with the state legislatures]."

In addition to a requirement for active surveillance cultures (ASC) for high-risk patients such as those admitted from long-term care facilities, the Pennsylvania law calls for hospitals to include in their infection control plans "procedures and protocols for staff who may have had potential exposure to a patient or resident known to be colonized or infected with MRSA or MDRO, including cultures and screenings, prophylaxis and follow-up care." The health care worker screening provision has caused an uproar since it was included in the July 12, 2007, law (Senate Bill No. 968).

Sharon Krystofiak, MS, MT(ASCP), CIC, infection control manager at Mercy Hospital in Pittsburgh, says they are struggling. "We have no idea where they pulled this verbiage out of thin air," Krystofiak says. "It says something like `according to established protocols.' There aren't any." It never has been a recommended practice,

she says. "Unfortunately, Pennsylvania has taken the tact of passing laws and then figuring out what they mean," Krystofiak says

The infection control community in Pennsylvania is rallying to try to get some reasonable interpretation of the provision as enforcement and compliance mechanisms are honed in the weeks and months ahead. The aspect of culturing staff is particularly broad: any staff that are exposed to MRSA, says **Patrick J. Brennan**, MD, chief of healthcare quality and patient safety for the University of Pennsylvania Health System in Philadelphia. "You can interpret that to be anybody that takes care of a patient with MRSA," Brennan says. "I'm not sure how they intend to implement that or what the implications are going to be. I think a lot of this is going to be subject to department of health interpretation. If this is strictly and broadly interpreted it could be very onerous."

A cautionary tale

The situation in Pennsylvania is being viewed as a cautionary tale for other states facing increasing involvement of legislatures in the clinical practice of infection control. In particular, more states are considering requiring ASC to identify patients with MRSA before they can spread the bacteria to others. However, it appears Pennsylvania is the first state to include screening health care workers, which is generally done by nasal swab and culture.

"There are exceptions, but the literature on MRSA largely suggests that health care workers' nasal carriage is not the source of spread of MRSA to patients within health care facilities," Schaffner says. "This [Pennsylvania] legislation appears misguided and is unlikely to have a noteworthy impact on MRSA transmission within health care facilities. It will raise all kinds of issues having to do with how frequently institutions should do [screening], who indeed is considered a health care worker in the context of this legislation, and what institutions ought to do after they have identified such an individual."

ASC for high-risk patient groups is controversial in its own right, but is generally seen as a potentially effective way to identify and isolate MRSA colonized patients so they can't spread infection to others. The health care worker screening provision — which sounds reasonable enough in the abstract — is another matter entirely.

Infection control experts have long emphasized that it is generally futile and counterproductive to routinely search for health care workers colonized with staph in the absence of an outbreak. Culturing the nares of health care workers does not address the primary threat to patients, which is the transient colonization of worker's unwashed hands as they go from patient to patient. Thus, hand hygiene between patients is the cardinal rule for health care workers to follow.

"We reserve screening for individuals who have an epidemiological association with some transmission event," explains **Michael Bell**, MD, medical epidemiologist in the CDC Division of Health Care Quality Promotion. If there is some reason to consider screening, that would be fine, Bell says. But if you screen at random, there is the challenge of interpreting the results, he says. "If somebody comes back with one or two organisms, do you continue to reculture them for some period of time? Do you try to decolonize them? If you can't decolonize, do you fire them?" Bell says. "I don't think you would be allowed to actually. There are all sorts of ramifications of a random culture that makes that a routine practice that we do not normally advise."

Rarely, persistently colonized workers will cause infections in patients, a legitimate issue that does warrant screening to protect patients. The CDC's latest guideline on MDROs includes a section on the issue of colonized workers that states: "Occasionally, HCP [health care personnel] can become persistently colonized with an MDRO, but these HCP have a limited role in transmission, unless other factors are present. Additional factors that can facilitate transmission include chronic sinusitis, upper respiratory infection, and dermatitis."[1] In a report published just this year, a neonatal specialist persistently colonized with a MRSA strain that eventually became mupirocin-resistant was implicated as a recurrent source of transmission in a newborn nursery.[2]

In general, the CDC recommends that hospitals should obtain cultures of health care personnel when there is epidemiologic evidence implicating the worker as a source of ongoing transmission. When decolonization for MRSA is used, perform susceptibility testing for the decolonizing agent, the CDC recommends. Limit decolonization efforts to culture-positive workers who have been epidemiologically linked as a likely source of ongoing transmission to patients. Consider reassignment of workers if decolonization is not successful and transmission to patients persists, the CDC emphasizes. "With MRSA, what we see is that people have skin eruptions,

broken skin, eczema, who become colonized on that part of their skin and can be transmittters of infection," Bell says.

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Plan complements disease management

Targets ill at risk for health care expenditures

Employees with chronic conditions that put them at risk for high health care costs but don't fall into traditional disease management programs are learning how to manage their conditions through the ComplexCare program from Health Management Corp.

"We've recognized for a long time that dealing with the core disease management conditions can have a positive outcome for people who are at risk, but there also are people with multiple chronic conditions who do not fall into traditional disease management categories but who account for a lot of expense and poor outcomes," says **Sam Cramer**, MD, chief medical officer for Health Management Corp. Health Management Corp., a wholly owned subsidiary of WellPoint, with headquarters in Richmond, VA, supplies disease management and case management for WellPoint and other clients.

ComplexCare helps employees avoid preventable episodes of care by seeing a physician regularly and following their care plan, complying with their medication regimen, setting lifestyle goals, and following healthful practices, such as dieting and exercising. The program provides outreach to at-risk employees who may have conditions such as cancer, multiple sclerosis, muscular skeleton problems such as fibromyalgia, and behavioral health conditions such as schizophrenia and bi-polar disorder. Employees with the core disease management conditions — asthma, diabetes, chronic obstructive pulmonary disease, heart failure, and coronary artery disease — are referred to the health plan's traditional disease management program.

Predictive model used to identify employees

The health plan identifies employees through a predictive model that is based on utilization and laboratory claims and targets those who appear to be at risk for future utilization. For example, the model identifies employees who regularly see three or more doctors, have three or more emergency department visits within six months, or have more than two hospital admissions in three months. Additional employees who might benefit from the program come from the results of a health risk assessment, referrals from physicians, and the health plan"s utilization management department.

When employees are identified, a health outreach specialist calls them on the telephone, explains the program to them, and enrolls them if they are willing to participate. The outreach specialists collect initial demographic information and then transfer employees to an RN care manager. The care manager verifies the employees' medical history and diagnosis, then conducts an assessment of their functional status, social and economic status, support system, and any needs they may have beyond their medical condition. "So many things besides a patient's medical condition have an effect on their health. We do a very complete assessment in terms of medication, transportation issues, the type of support they have at home, and use the information to develop a care plan that looks at all of their needs and what we can do to help," Cramer says.

The care managers provide information that helps the employees understand their conditions and their medication instructions. They work with the employees to develop a care plan that includes lifestyle goals and health-related priorities. The goals are based on the most important steps that the employee should take to stay healthy, "and at the same time, the care manager takes into account what goals the individual is most ready or most willing to work on. They have to balance the two," Cramer says.

For example, if the employee needs to stop smoking or lose weight but isn't ready to address that issue, the care manager and employee may

decide to start to work on medication compliance and tackle smoking or weight loss later. "It's not just the nurse and clinicians who drive the care plan. We want the individuals to buy into it," Cramer says.

The care manager may contact the employee's primary treating physician to determine or clarify a plan of care for the employee. The care manager notifies the physician that the employee has enrolled in the program, shares the employee's care plan and the goals, and provides status updates. The care managers work with the employees to help them follow their physicians' plans of care. One of the roles of the nurse care manager is to make sure the employees have providers and see them on a regular basis, Cramer says. "Some have lost contact or don't have a primary care provider," he says. The care managers facilitate getting the employees in to see their physician, Cramer says.

The plan has medical director oversight at every call center who reviews the new employees and is available for consultation if the care manager needs information or if the treating physicians have a question.

Employees are stratified by acuity level, which drives the frequency of the telephone calls from the care managers. The nurse care managers call participants at least once every six weeks. Employees also can contact the nurses with any health-related questions using a toll-free number.

The program is designed to provide support for six months to a year to help employees meet their health care goals. If an employee still is not meeting his or her goals after a year, the nurse care manager consults the medical director to determine if the employee still is appropriate for the ComplexCare program or if he or she might benefit more from a different type of program.

The care managers help employees obtain referrals for specialty care, home health services, durable medical equipment, and other needs. They also work with employees to help them obtain community services such as free transportation for health care visits or other services. Beyond dealing with the clinical issues, they help the employees find the resources they need to solve their problems, Cramer says.

Care managers at call centers around the country coordinate the care of employees nationwide. The care managers have resource guides for individual areas and rely on other colleagues at other locations for help identify community organizations that can help the employees. "The nurse care manager is the expert in terms of resources. They don't know every resource in every location, but they know how to find them," Cramer adds.

The care managers also conduct assessment screenings to identify employees who might benefit from a mental health program. "People with chronic conditions frequently become depressed, and depression can have an impact on their medical condition. They may not be as compliant as they should be because of mental health issues," he says.

If the care manager identifies that the employee has severe behavioral health or mental health issues, she connects him or her with a mental health program and follows up to make sure that the employee has kept his or her appointments.

The care managers assigned to the employee work with the pharmacy staff on medication compliance. They can consult with exercise physiologists, dieticians, and other ancillary providers if needed. ■

Program helps workers manage their weight

A newly diagnosed diabetic, we'll call him Mr. Smith, called in to Capital District Physicians' Health Plan Health Coach Connection because his doctor had told him he needed to undergo gastric bypass surgery if he was going to live another 10 years.

Smith was concerned and wanted to explore other options.

The health coach sent the employee a decision-support video along with information on diabetes, nutrition, and healthy lifestyles. The health coach also referred the employee to the health plan's Weigh 2 Be weight loss program, which provides adults with multiple resources for weight loss and healthy lifestyle choices, including interactive web-based tools to design customized weight loss plans and fitness programs, and offers community classes and other support.

Smith decided not to have the surgery but, with the help of the multidisciplinary team at the health plan, worked on losing weight and exercising. Health Coach Connection staff spoke to the employee 11 times in eight months offering him help with losing weight and getting his diabetes under control. He lost 65 pounds in seven and a half months, got his blood sugar under control to the extent that he could stop taking

medication for diabetes, and is scheduled for sessions with a respiratory therapist who will help him quit smoking.

"This illustrates how the various departments within our health plan collaborate, trying to keep people healthy and out of the hospital," says **Mary Ann Roberts**, RN, health educator for the Albany, NY-based health plan.

Nurses, dieticians, respiratory therapists, case managers, and disease managers at Capital District Physicians' Health Plan and Health Coach Connection work together to ensure that employees have all the tools and support they need to maintain a healthy lifestyle. The health plan offers Weigh 2 Be for adults and KidPower for children, both programs that help participants learn to manage their weight and improve their health. The health plan started its adult weight management program in April 2003 to respond to the increased prevalence of obesity and comorbidities, such as hypertension and diabetes, that are linked to diabetes, Roberts says.

The program is designed to help participants learn to manage their weight and improve their health, and the statistics have been encouraging, Roberts points out.

In 2006, 79% of adults responding to the health plan's Weigh 2 Be program reported reductions in their body mass index.

Capital District Physicians' Health Plan sent out an introductory mailing describing the Weigh 2 Be program to more than 30,000 members with diabetes and/or hypertension. In addition, adults are referred to the Weight 2 Be program by their physicians, nurse case managers, or by self-referral.

When employees enroll in the program, they receive a packet of information on nutrition, stress management, fitness, a discount on the purchase of a pedometer, and a rebate offer of $64 off the completion of a 10-week Weight Watcher's program. "We partnered with Weight Watchers since this was the most sound and evidence-based weight loss resource. It helps participants learn portion control and how to eat healthfully," Roberts says.

Employees who sign up for the program can access interactive fitness and weight loss tools on the health plan's web site. They can enter their weight and other measurements on the site to determine their body mass index, and they can calculate the number of calories they are consuming each day by entering information on what they eat and drink.

In response to survey results from employees who wanted more personal contact, in May, the health plan developed a Weigh 2 Be pilot program of six, one-hour classes in the community. Experts speak to participants on topics ranging from hypertension and stress management to cooking and exercise demonstrations. Employees weighed in each week and received a small incentive each week, such as a stress ball, fitness bands, or portion control dishes. About 60% of enrollees participated in all six classes.

"We want to give them the resources they can use at home to be successful in their weight loss efforts," Roberts says.

Because the class attracted participants from

CE Objectives / Instructions

The CE objectives for *Occupational Health Management* are to help nurses and other occupational health professionals to:

- Develop employee wellness and prevention programs to improve employee health and productivity.
- Identify employee health trends and issues.
- Comply with OSHA and other federal regulations regarding employee health and safety.

Nurses and other professionals participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with this issue, you must complete the evaluation form provided in this issue and return it in the reply envelope provided in order to receive a letter of credit. When your evaluation is received, a letter of credit will be mailed to you.

COMING IN FUTURE MONTHS

- Foolproof strategies to help workers with burnout
- Update on worker's compensation fee schedules
- Justify prevention programs by IDing top cost drivers
- New technology that gets employees to exercise at work

their 30s to their 80s, the speakers covered subjects that would be of interest to everyone. For instance, the fitness instructor taught exercises that people could do sitting down or standing up, as well as in wheelchairs.

The health plan offered a second round of Weigh 2 Be six-week programs again in September. More than 125 persons enrolled in the second round, and many of those had participated in the first pilot program. In October, the plan started sending a quarterly newsletter to Weigh 2 Be participants. "Each quarter will address different options for making healthier lifestyle choices," Roberts says. ■

CE *questions*

21. Which is true regarding employees participating in a depression screening and intervention program for 604 employees from 16 large employers?
    A. There was no clear return on investment for the intervention.
    B. Employees receiving the intervention worked an average of two hours more per week.
    C. The cost of the intervention was greater than the financial benefit of increased productivity.
    D. The duration of short-term disability claims increased.

22. Which is recommended for occupational health managers to reduce litigation risks of the Family and Medical Leave Act?
    A. Don't rely on written policies and procedures.
    B. Avoid documenting excessive leave.
    C. Obtain and retain medical documentation for leave.
    D. Challenge intermittent unscheduled absences even before a pattern of abuse is suspected.

23. Which is true regarding long-term success for smoking cessation, according to new research?
    A. Smokers with non-smoking spouses were less likely to quit.
    B. Smoke-free workplaces played no role in success.
    C. Couples smoking cessation counseling is ineffective.
    D. Individuals whose workplaces were completely smoke-free are more likely to have long-term quitting success.

24. Is the following statement true or false? The ComplexCare program from Health Management Corp. does not consider utilization as a factor in identifying employees.
    A. True
    B. False

Answers: 21. B 22. C 23. D. 24. B.

Occupational Health Management™
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When looking for information on a specific topic, back issues of Occupational Health Management, published by AHC Media, LLC, may be useful. To obtain back issues, contact our customer service department at P.O. Box 740060, Atlanta, GA 30374. Telephone: (800) 688-2421 or (404) 262-5476. Fax: (800) 284-3291 or (404) 262-5560. E-mail: custsomerservice@ahcpub.com.

Occupational Health Management

A monthly advisory for occupational health programs

OHM120107TM

CNE Evaluation

Please take a moment to answer the following questions to let us know your thoughts on the CNE program. Fill in the appropriate space and return this page in the envelope provided. **You must return this evaluation to receive your letter of credit**. Thank you.

CORRECT ● **INCORRECT** ⊘ ✓ ✗ ⌇

1. If you are claiming nursing contact hours, please indicate your highest credential: ○ RN ○ NP ○ Other _____

After participating in this program, I am able to:	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**
2. Develop employee wellness and prevention programs to improve employee health and productivity.	○	○	○	○	○	○
3. Identify employee health trends and issues.	○	○	○	○	○	○
4. Comply with OSHA and other federal regulations regarding employee health and safety.	○	○	○	○	○	○
5. The test questions were clear and appropriate.	○	○	○	○	○	○
6. I am satisfied with customer service for the CNE program.	○	○	○	○	○	○
7. I detected no commercial bias in this activity.	○	○	○	○	○	○
8. This activity reaffirmed my clinical practice.	○	○	○	○	○	○
9. This activity has changed my clinical practice.	○	○	○	○	○	○

If so, how? _____

10. How many minutes do you estimate it took you to complete this entire semester (6 issues) activity? Please include time for reading, reviewing, answering the questions, and comparing your answers to the correct ones listed. _____ minutes.

11. Do you have any general comments about the effectiveness of this CNE program?

_____

I have completed the requirements for this activity.

Name (printed) _____ **Signature** _____

Please make label address corrections here or PRINT address information to receive a certificate.

PLEASE NOTE: If your correct name and address do not appear below, please complete the section at left.

Account # _____

Name: _____

Company: _____

Address: _____

City: _____ State: _____ Zip _____

Fax: _____ Phone: _____

E-mail: _____