

Case Management

ADVISOR™

Covering Case Management Across The Entire Care Continuum



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In-home monitoring helps at-risk veterans manage their health

Program reduces home care, ED visits, and hospitalization

Remote monitoring by trained telehealth care coordinators has improved the outcomes and saved costs for high-risk chronically ill patients in the VA Connecticut Healthcare System.

The telehealth program is an adjunct to the VA Connecticut's case management program in which the same nurses and social worker case managers follow the patients through the continuum, from the hospital to the community and back again.

"Telehealth is a tool that we use to augment primary, specialty, and mental health care services. Home telehealth allows for close monitoring and timely intervention based on data sent by patients from their homes. It has reduced the need to return to clinics for routine follow-up monitoring, has reduced the number of skilled home care visits, and has reduced emergency department visits and hospitalizations," says **Donna Vogel**, MSN, CCM, program director, care coordination and case management.

Patients who will benefit from telehealth

The telehealth program targets patients who are most at risk for decline, including those who may live alone, lack caregiver support, or those who are having trouble with self management and want to be more involved with their own health care.

Patients who are appropriate for telehealth may be failing at home, have out-of-control blood sugar or blood pressure, or other conditions that put them at high risk for emergency department visits or hospitalization.

"Not all patients would qualify for telehealth and some want nothing to do with having a device in their home," Vogel says.

Patients eligible for home health must have a home with a working telephone line.

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The technology used at VA Connecticut's telehealth is user-friendly. Some of the devices allow for peripherals to plug into the unit to collect data to monitor blood pressure, pulse, weight, temperature, pulse oximetry, and finger-stick glucose.

"Some technology delivers patient education and allows the case managers to schedule reminders for a patient to take his or her medication or to perform a measurement," Vogel says.

Videophone technology helps veterans, nurses

Veterans who are home bound and have few interactions with the outside world can use videophone technology to communicate face to

face with the RN telehealth care coordinator.

The videophone technology has allowed the care coordinators to identify patients whose condition has declined and to arrange for them to come into the hospital or clinic for care, Vogel adds.

The technology also can be used to monitor spinal cord injury patients for decubitus ulcers and other problems.

To identify patients eligible for the program, the case management department mines its data for high-cost, high-utilization patients with chronic diseases. Clients can be referred by primary care providers, specialist providers, or other clinicians.

Because it has received so much national attention, patients read about the VA and its telehealth programs and feel they could benefit from more frequent monitoring, Vogel says.

When someone is referred to the program, the case manager conducts an assessment of their health care needs. When the care coordination office gets a referral, a case manager conducts an assessment to determine what services the VA can offer and that the patient can benefit from receiving.

If the assessment shows that monitoring the patient's health more frequently can keep him or her out of the hospital and that the patient and/or caregiver are willing to use home health technology, the case manager refers the case to the telehealth coordinator.

The telehealth coordinator identifies what technology is most appropriate for each patient and configures the devices to make sure that the right dialogues are set up.

The telehealth coordinators enroll the eligible veterans in the program, get their consent, and educate the patient and caregiver on the equipment and how to use it. The education may take place on the hospital unit, at the case management office, or in the primary care clinic.

"We get the equipment configured, educate the patient on how to use it, and the patient can take it home with them that day," Vogel says.

The patients have instructions on how to install the equipment but if they have difficulty, the VA calls in a durable medical equipment contractor to help.

The telehealth care coordinators are all registered nurses who have completed an intensive web-based training program offered by the Office of Care Coordination Services in the VA Central office. They must complete competencies in tele-

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health coordination and undergo annual training.

They collaborate with the patient's interdisciplinary team to monitor the patient's condition and make sure his or her needs are being met.

If a patient who is being telemonitored is hospitalized and needs additional case management services such as a skilled nursing visit to the home for wound care or home infusion services, the telehealth care coordinator hands the patient off to the case management department to avoid duplication of services.

Back and forth communication

Each day, the patients use the telehealth unit to check their vital signs and send data on weight, blood pressure, blood oxygen, temperature, or other data needed to a secure web site monitored by the telehealth care coordinator.

If the data indicate that the patient's condition has worsened or his or her health is at risk, the telehealth care coordinator will call the patient and confirm that the data sent were obtained correctly and that any out-of-range responses to disease-specific survey questions were entered correctly. Depending on the data received, the telehealth coordinator will provide patient education, discuss the findings with the patient's primary care clinician, or recommend that he or she go to the emergency room or be seen at the clinic.

If the patient fails to enter the data, the telehealth care coordinator calls to remind him or her to send data and to make sure everything is OK.

The telehealth care coordinators monitor the site every business day to identify potential problems in real-time. They remind patients that data they send from home isn't viewed on weekends and holidays and reinforce the importance of self-management and knowing when it's critical for them to seek urgent or emergent care.

"We dedicated staff to watching the telehealth web site so they can see the data when they come in. When the patients' case managers were responsible for watching their own patients who were on telehealth, there was frequently a delay in viewing and intervening on data sent from the patient's home because the case manager was often busy seeing patients in the clinic or on the inpatient unit," Vogel says.

Where CMs come in

At VA Connecticut, part of the VA New England Healthcare System, case managers are specially

trained RNs and social workers assigned to care lines as well as to a panel of providers where the patient receives primary care. The providers may be a physician, an advanced practice registered nurse, or a physician assistant in the VA health system.

Services provided by the case managers include assessment, care planning and implementation, education, referral, coordination, advocacy, monitoring, and periodic reassessment to meet an individual's health care needs.

The case managers see the patients in the clinic, hospital, or may need to follow them in a skilled nursing facility if the patient requires skilled nursing care. They may need to coordinate with hospice care or work with any other VA and non-VA providers to ensure seamless coordination of care.

"The constants in the patients' health care continuum are the nurses and the social worker case managers. Wherever that patient is, the care is coordinated by the same RN/social worker case management team to promote continuity. It's an efficient way to coordinate care and the patient always knows who is handling his or her care," Vogel says.

If a patient needs specialized case management, such as the telehealth monitoring, surgery, specialty care, or inpatient services, he or she may be handed off to another case manager. The primary case manager will be kept informed about the patient's condition and changes in the patient's health care needs. After the specialty or episodic case management needs are met, the specialty case manager will hand back the patient to the primary case manager.

The care of veterans who are receiving intensive mental health treatment may be coordinated by a mental health case manager.

"We may hand off our patients when there are specialized case managers and services that can help meet the patient's needs with the understanding that the patient will be referred back to the primary case manager once he or she no longer needs or is benefiting from specialized case management services. We don't want to duplicate services and we want to get the best trained case managers for that specific event or care need," Vogel says.

Case managers are assigned to clients who are at high risk for utilization including those who have been hospitalized for a crisis episode or those who have recent or repeated hospitalizations, as well as those with chronic illnesses.

Chronic conditions include diabetes, congestive heart failure, chronic obstructive pulmonary disorder, chronic pain, spinal cord injury, hypertension, and end-stage renal disease.

VA Connecticut has an elaborate computerized patient record system that allows for the case manager to access information at whatever point the patient is in the continuum. When there is a change in patient status or an event that requires case management, it's easy for the case manager to access the information. ■

Health plan targets the medically underserved

Programs engage community providers, civic leaders

By collaborating with hospitals, schools, and members of the community, UPMC Health Plan is providing health care services to a population that has traditionally been underserved.

The Pittsburgh-based health plan has been awarded the Recognizing Innovation in Multicultural Health Care Award by the National Committee for Quality Assurance for providing culturally and linguistically appropriate health care services for its members in Western Pennsylvania.

The health plan provides commercial benefit plans, Medicare, and Medicaid through the Pennsylvania Medical Assistance Program.

The health plan studied the outcomes for members covered by the medical assistance program and identified areas in the community where access to medical care as well as medical care outcomes are poor compared to the commercial population.

"We concentrated on members in areas with the lowest access to health care and the lowest HEDIS scores and targeted a program to improve the delivery of health care services and subsequently the outcomes to this population," says **Michael Culyba**, MD, vice president of medical affairs, health disparity.

The health plan has developed three programs in the economically depressed and medically underserved areas. UPMC for You, the health plan's medical assistance program has partnered with hospitals to provide support for pregnant women and their children. Through a partnership with a community school, the health plan is

ensuring that children receive preventive care, recommended vaccinations, and dental care. The third program partners with a hospital to recruit community leaders who educate residents about the health plan's disease management programs for childhood asthma and adult diabetes and cardiac disease.

The maternity program targets the Braddock area, formerly a steel workers neighborhood that is now a low income area with scarce health care services.

"Poor birth outcomes, particularly low-birth-weight infants, were significantly higher in this community than in the medical assistance population as a whole. We partnered with community hospitals and physicians in the area to improve prenatal care for women in this area," Culyba says.

Prenatal care provided

The insurer collaborated with representatives from UPMC Braddock community and McGee Women's Hospital of UPMC, physician practices that are a part of UPMC, and federally qualified health centers to improve access to prenatal care for women living in the area.

"This was accomplished by creating community awareness by engaging hospitals and practicing physicians, community agencies, and community civic leaders; by developing communication tools to inform the community of maternity programs and the value of appropriate prenatal care; and by coordinating the identification of at-risk pregnant members and referring them to appropriate clinical services, including a doula program we developed," Culyba says.

Members eligible for the program are identified primarily through an obstetrical needs assessment form that physicians are required to fill out for patients who are covered by Pennsylvania's medical assistance plans.

Women in the neighborhood are largely transient without regular access to telephone and have tremendous psycho-social needs.

"One of the issues we recognized is that telephonic disease management is not effective with this particular population. Peer-to-peer support is much more effective than someone from a corporate office calling them," Culyba says.

Working with East Liberty Family Practice, a large physician practice group, and the federally qualified health centers, UPMC Health Plan has created a doula program to provide support dur-

ing pregnancy, labor and delivery, and beyond.

“Doula” is a Greek word that means a specially trained women who “mothers the mother” and assists her through pregnancy and delivery and helps her understand her role as a parent.

The health plan recruited women from the Braddock community and put them through a training and educational program that includes motivational interviewing and meets the requirements for a doula certification program.

The program provides pregnant members who chose to participate with six prenatal visits and four post-partum visits.

“When we identify a member for the program, we refer her to one of the doulas who makes personal contact and follows her through the pregnancy and delivery and helps transition her and her baby into better pediatric care,” Culyba says.

The doula identifies any risks to a healthy pregnancy and points the member to services that would help. For instance, if the woman is a smoker, the doula will refer her to a smoking cessation program. If she needs transportation, housing, or food, the doula helps her access community agencies that can help with those needs.

“Our feeling is that peer-to-peer communication creates a social bond and the woman who is in need is more likely to respond,” Culyba says.

The doulas communicate with UPMC’s maternity program, using tools that outline their visits with the women and what headway they have made.

Magee Women’s Hospital of UPMC, which performs the majority of deliveries for women in the Braddock area, allows the doulas to attend the delivery with the women and help them through the labor and delivery process.

After the baby is born, the doula makes a post-discharge follow-up visit to make sure the mother and child are doing well and that the child is getting good pediatric care.

Participants in the program have shown a significant increase in breast feeding, an increase in having a prenatal visit in the first trimester, and a decline in low-birth-weight babies.

Targeting school-age kids

In another community project, the health plan has been working for about a year with the school nurse at a community school to identify members who haven’t gotten the recommended immunizations or who haven’t seen a dentist. The health plan coordinates with the nurse to

ensure that the children get the necessary medical care.

“UPMC Health Plan functions as a coordinating entity between the school, the child and family, and the health care practitioners,” Culyba says.

If the health plan’s data analysis shows that a member hasn’t had a recommended immunization or isn’t getting regular dental care, the health plan’s care coordinator tries to get in touch with the family.

If the health plan can’t contact the family and the child is a student at the school, the case manager alerts the nurse who calls the student in and talks to him or her.

“We have created a communication vehicle. If we can’t contact the parent, we ask for help from the school. We know that these children have to go to school so we work with the school nurse to get in touch with the child and parent and we coordinate a visit with the primary care practitioner,” he says.

The health plan has been piloting the program in one school for about a year.

The school nurse and the case manager work together to make sure the student gets the care he or she needs.

“We provide care management services for our members and work with the school nurse to improve the medical care for our members,” Culyba says.

Through a partnership with UPMC Braddock, the health plan is helping people with chronic conditions who live in the Braddock community learn to manage their diseases.

With the help of the health plan, the hospital has recruited community ambassadors to educate the public about its Steps to Health program, which provides disease management for adults with diabetes and cardiac disease and children with asthma.

“We know that peer-to-peer communication is an effective way to engage members, particular those in our medical assistance programs. We want to create awareness of these disease management programs and to work with the hospital to ensure that members with these conditions are referred into our clinical program,” Culyba says.

UPMC Health Plan and UPMC Braddock train the ambassadors about the health plan and hospital-based disease management programs, including how to identify people who would benefit from the program and refer them to UPMC Health Plan.

The health plan assists the hospital in developing and implementing disease management programs for people with chronic conditions who are without health insurance. The health plan has representatives on the hospital's disease management steering committee and coordinates clinical activities with the hospital to make sure that the care is consistent for all members of the community.

"The role of the hospital is changing, particularly when it is in a depressed area. Instead of just taking care of people when they're sick, the hospital's role is evolving to recognize the value of prevention and to become a leader in developing clinical programs to help prevent and manage chronic diseases," Culyba says. ■

CMSA: Medicare should pay for care services

Organization asks CMS to change reimbursement

The Case Management Society of America (CMSA) has requested that the Centers for Medicare & Medicaid Services (CMS) revise a recent ruling and make a number of care coordination services payable.

In its interim final rule for the 2008 Physician Fee Schedule, CMS created six assessment and care coordination CPT codes, which were assigned a relative value unit but were given an "N" status, meaning that they will not be reimbursed by Medicare.

Three of the codes pertain to telephone evaluation and management services provided by a physician to an established patient, parent, or guardian.

Three non-physician codes were issued for telephone assessment and management services provided by a qualified non-physician health professional, such as a case manager.

The codes specify that the services must not originate from a related assessment and management service provided within the previous seven days or lead to assessment and management services or a procedure within the next 24 hours.

In a letter to CMS, CMSA stated that the six codes would create incentives for assessment and management services that include transition of care coordination, medication reconciliation, health literacy, patient medication knowledge, readiness to change assessments, motivational

interviewing, patient education, and medical home coordination.

"CMSA believes that by requesting funding support for these six codes, providers will more readily integrate case/care managers in the support of the care coordination concepts, such as the Medicare Medical Home Demonstration, pay-for-performance programs, and various collaborative care models, which CMS and other regulatory agencies are discussing," CMSA officials wrote in the letter to CMS.

The change will help every care manager provide better, more effective services to their patients, control costs for their organizations, and incentivize their companies in dedicating resources to solving care coordination issues, points out CMSA President **Peter Moran**, RN, C, BSN, MS, CCM.

CMSA is concerned that failure to provide financial reimbursement for those practices continues to misalign incentives and priorities that will negatively impact care delivery to patients, he adds.

"Currently, case managers work in a collaborative manner with physicians, pharmacists, and other care managers, such as social workers, to best coordinate patient care between different professionals and different practice settings. Without the appropriate financial funding for these types of services, health care providers have less incentive to provide this type of coordination and many cannot fund such initiatives on their own," adds **Teri Treiger**, RN-C, MA, CCM, CCP, CPUR, CMSA director and CPT committee project leader.

When the interim final rule was released in November, CMSA urged its members to write to CMS, asking the agency to provide failure reimbursement for the practices covered by the assessment and care coordination codes. The public comment period ended on Dec. 31.

"The good news is that we now have codes for care coordination. The next step is to get them reimbursable," Moran said.

Also in its interim final rule, CMS clarified the definition of covered case management and targeted case management services and added measures to address concerns about improper billing of non-Medicaid services by some states.

CMS defines case management as "services which help beneficiaries gain access to needed medical, social, educational, and other services." It defines targeted case manager services as those aimed at special groups of enrollees, such as those with developmental disabilities and chronic

mental illness.

The new rule specifies that case management services include an assessment of an eligible individual, development of a specific care plan, referral to services, monitoring, and follow-up. It specifies that direct services, such as transporting a person to an appointment or court appearance, are not allowable. ■

Costs of hospice care less for most end-of-life patients

Quality care and cost savings coincide

Hospice managers have long suspected that their care both improves quality and saves payers money. Now there's a major research study of Medicare end-of-life patients that demonstrates that hospice care saves money for most end-of-life patients.

Managers can use the study's findings to demonstrate the value of their services to health system executives and referral sources, including physicians.

The study found that hospice use reduced Medicare program expenses during a patient's last year of life by an average of \$2,309 per person enrolled in hospice care.¹ Hospice use also saved Medicare a maximum cost savings of about \$7,000 per hospice patient when the hospice care was provided for about two months.¹

"For the last 25 years or so, people have been interested in the question of 'Does hospice reduce health insurance costs to Medicare?'" says **Donald H. Taylor Jr.**, PhD, an assistant professor of public policy studies at Duke University and an assistant professor of community and family medicine and nursing at Duke Medical Center in Durham, NC. Taylor is the lead author of the new Duke study that provides a hearty "yes" to the cost-savings question.

"It seems like a straightforward question to answer, but the tricky part is that people who tend to use hospice are different than those who don't use hospice," Taylor says. "Our study tries to statistically account for the difference between the two groups."

The Duke study is one of the most important to date on the topic of hospice costs because it compares apples to apples among Medicare beneficiaries, says **Jon Radulovic**, spokesman for the

National Hospice & Palliative Care Organization (NHPCO). "The methodology used in this study was very thorough," Radulovic says. "What's interesting is the finding that by increasing hospice stay even by a couple of days, you can increase that savings by another couple of hundred dollars."

The study, which was conducted from 1995 to 2003, identified people who were very similar to hospice users in their demographics and past health care experiences, but had the one difference of not having used hospice care in their last year of life, Taylor explains. Researchers subsequently determined the daily costs of each group. Much of hospice's cost savings could be attributed to one primary difference between the two groups: "People who are using hospice are not as likely to die in the hospital as people who don't use hospice," Taylor says.

Hospital care is very expensive

Recent government scrutiny and media attention have focused on the hospice patients who have very long lengths of stay (LOS) and the hospices that have a disproportionate number of such patients. For example, a recent article in *The New York Times*, highlighted a handful of for-profit hospices that have exceeded the Medicare cap on per patient expenditures because they have a large number of patients who have long lengths of stay.²

But across the nation, the longer-stay patients are less common than the patients who are referred to hospice too late to receive the full benefits and best quality of care, Taylor notes.

The 25th percentile of hospice LOS is five days, meaning that one out of four hospice patients receive hospice care for five days or less, Taylor explains.

If these same patients were to double their lengths of stay, it would save Medicare money, and this is the area in which cost-savings efforts should be focused, Taylor says.

As the study notes, the longer LOS would save Medicare money because it is a patient's last week and days in hospital care that is the most expensive health expenditure. Thus, when a hospice patient is referred to hospice care at home two weeks before his or her death, it saves Medicare the difference between what would have been spent in hospital care vs. what is spent in hospice care. This amount increases the longer a patient is in hospice care for all but the minority

of patients with very long LOS.¹

Additionally, most people who work in hospice care or who have had loved ones who received hospice care would say that hospice care enhances the quality of care, Taylor says. "And our study shows hospice would save Medicare money," he adds. "There is almost no other example I can think of showing something that improves quality of life and saves money."

Goal is quality — not lowest cost

While the Duke study is welcome news to an industry that is undergoing federal scrutiny and regulatory changes, it also might reinforce the idea that hospice care should reduce health care costs, says **Porter Storey**, MD, executive vice president of the American Academy of Hospice and Palliative Medicine.

"The thing we have to watch about studies is [the reality] that no care is always cheaper than good care," Storey says. "The goal here is not to have the lowest cost."

It's an interesting and fair question to ask whether hospice care should be expected to save money for the Medicare program, Taylor says. "We don't ask whether coronary bypass surgery saves Medicare money," he adds. "It's interesting that the hospice program is subjected to that question of whether it saves Medicare money when no other part of medicine is."

While the Duke study's findings are very positive for the hospice industry, it's unlikely the one study will settle all questions about hospice's value in the Medicare program. **Stephen Connor**, PhD, vice president for research and international development at (NHPCO), says, "The thing about hospice cost research is I'm not sure we'll ever be able to have what is referred to as a definitive study, because we can't randomize patients to hospice."

"The study is as good as how well you match subjects," Connor says. "This study has done a better job than any previous study in doing that, and it's the best we have at this point."

The study has caught the attention of the government, and its timing led to notice at the fall meeting of the Medicare Payment Advisory Commission (MedPAC), where one MedPAC member mentioned its findings.

"MedPAC has some interest in how hospice is financed," Taylor notes. "The two groups of most interest from a policy perspective are people who use hospice three to four days before death, and

there's a concern whether they reap all of the benefits of hospice care. The second group is of people who use hospice for more than 180 days, which is about 5% to 6% of Medicare beneficiaries." It's this second group that has drawn more attention from MedPAC, Taylor says.

MedPAC worries most about long LOS

MedPAC is worried that these long lengths of stay represent something fraudulent to hospice, Taylor says.

"It appears to us that most of those cases of longer LOS occur when the clinical condition of the patient changes," Taylor says. "Death is not the simplest thing to predict, and we think more attention should be paid to the shorter LOS."

The Duke study found that for the entire last year of life, people who received hospice care cost Medicare \$32,727, nearly the same as the \$32,837 cost for people who did not receive hospice care in their last year of life.¹ Also, hospice cancer patients who were in hospice care for 233 days or longer and noncancer patients who were in hospice care for 154 days or longer actually cost the Medicare program more than normal hospital-based and other medical care.

Policy makers should focus on decreasing the numbers of people who enter hospice care too late to reap the full quality of life and Medicare cost-savings benefits, Taylor suggests. This could happen with a simple policy change that allows end-of-life patients who wish to continue to receive curative medical care to also receive hospice care, he says. "Most people who are coming to hospice late or for such short periods is because of restrictions on curative treatment for hospice," Connor says. "What happens commonly is people want to continue some disease-modifying therapy with the goal of remission or cure even up to the point of near death."

End-of-life patients who don't receive hospice care until the last few days of their lives are missing out on some of the significant benefits that hospice can offer them, Storey says. "I have had many patients who finally became comfortable when they received hospice care, and they were furious with me because they had been miserable for so long," Storey says. "They'd ask, 'Why didn't I receive that kind of care sooner?'"

The Medicare program makes an unnatural division between end-of-life patients who choose to continue curative treatments and those who choose to enter hospice care and discontinue all

such treatment, Storey says. "Everyone else in countries around the world looks at our system as a real aberration because it puts a financial barrier between hospice care and hospital care," Storey says. "In Great Britain, Australia, and Canada, you can get a CT scan and be referred to a specialist while on hospice care."

Some hospices have gone out of business because they couldn't afford the short-term and intense palliative treatment needed by end-of-life patients who continued to receive medical interventions for their cancer until they were very sick, Storey notes. By the time such patients are referred to hospice care, they cannot swallow and must receive infusions and additional staff to help them become comfortable, he adds.

If these same patients had been referred earlier, while they still received medical interventions, then the overall hospice cost would have been lower, and it would have been easier and less expensive for the hospice to make them comfortable, Storey says.

Patients who are referred to hospices sooner are those who have accepted that their disease cannot be cured, and so they're ready to stop curative treatment and receive the symptom relief and other services that hospice can offer to end-of-life patients. "Most patients who come on to hospice care are getting much more intensive care in what matters to them most: pain, shortness of breath, the family pulling their hair out," Storey says. "But they have to face the reality that they have something that can't be cured."

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Risk of second heart attack doubles with job stress

Do a better job of reaching out to workers with burnout

When an employee returns to work after a heart attack, chronic job stress doubles their risk for another coronary heart disease event,

according to a recent study.¹

After 972 men and women, aged 35 to 59 years, came back to work after a heart attack, researchers performed follow-up at regular intervals between February 1996 and June 2005. Patients were first interviewed about six weeks after their return to work, then two years and six years later. During the last follow-up, researchers found that 206 employees had a confirmed recurrent coronary heart disease event, including 13 deaths. Chronic job strain (defined as high psychological demands and low decision control) was linked with a twofold increased risk in these workers.

To make the problem even more challenging, workers with burnout are less likely to participate in stress reduction or occupational training and are at risk for taking inappropriate antidepressants, says another study.² Researchers surveyed 3,276 Finnish employees aged 30 to 64 about burnout (defined as exhaustion accompanied by feelings of incompetence or that one's work isn't valuable). They found that 25% had mild burnout symptoms, and 2.4% had severe burnout.

Workers with severe burnout were about 40% less likely to participate in work practice improvement, occupational training, stress reduction, or vocational rehabilitation programs. However, these workers were more likely to take medications for mental health problems, with increased rates of antidepressant use even after adjustment for the presence of depression and anxiety.

These data suggest that in some cases burnout has been misinterpreted as a mental disorder requiring medications, says **Kirsi Ahola**, the study's author and a researcher at the Finnish Institute of Occupational Health in Helsinki. "Especially when they have no contact with the patient's workplace, doctors may feel medications are the only help they can offer," says Ahola.

In fact, the most effective interventions for workers with burnout combine individual and occupational approaches, says Ahola. "Successful recovery from burnout includes accommodations and activities to restore health and support," she says. "Occupational health professionals can suggest workplace modifications based on scientific evidence." Examples of these modifications are clarified responsibilities, reassigned tasks, increased flexibility and supervisory support, and training, says Ahola. Encourage workers to

actively communicate with supervisors about the new work arrangements, advises Ahola. "If necessary, additional support for these discussions from occupational health professionals should be considered," she says. "A follow-up should also be arranged to ensure successful recovery."

Identify cause of burnout

In most cases, the most effective interventions focus on the organization, *not* the worker, says **Mary K. Salazar**, EdD, RN, COHN-S, FAAOHN, FAAN, professor in the Department of Psychosocial and Community Health at the Seattle-based University of Washington School of Nursing.

Several studies provide evidence that excessive workloads, role ambiguity, conflict, and lack of social support are major contributors to occupational stress and worker burnout.^{3,4,5}

"Management's leadership styles have also been related to stress and burnout. Over-demanding employers are particularly problematic," says Salazar.

A first step in dealing with stress-related problems is to determine if employees are suffering from burnout and, if they are, determine the root cause, says Salazar. For example, burnout may be related to work overload, lack of control, no sense of personal accomplishment, or an intolerant employer, she explains. "Once the cause of the burnout is identified, then it can be addressed," says Salazar.

In most cases, it is not useful to require employees to attend self-help classes such as stress reduction, according to Salazar. "Studies have found that workers suffering from burnout tend not to attend these classes," she says. "Furthermore, individually focused strategies such as counseling or medication do not address the problem of burnout."

However, when there are indicators of psychological problems, workers *should* be evaluated for depression and anxiety, which would require a different type of intervention, she says. "But even in these cases, if burnout is a part of the problem, it needs to be addressed through some type of workplace intervention," says Salazar.

Prevention is key

Leaders at Philadelphia-based GlaxoSmithKline believe it is more important to prevent worker burnout, rather than waiting to devote a great deal

of resources once someone is approaching burnout, says **Ann Kuhnen**, MD, MPH, vice president of employee health management. A two-day "Energy for Performance" course given by trained facilitators at the Orlando, FL-based Human Performance Institute was piloted in one of the company's businesses with 350 participants, and it now is being offered to all employees onsite each month during 2008.

"It is geared at helping people become better stewards of energy so that they can best engage when it really matters, at work and in personal life," says Kuhnen. "Participants learn to maximize their energy by fully engaging their hearts, minds, spirits, and bodies in completion of the important missions they take on each day. If heeded, this is a fundamental step in avoiding burnout."

Employees can also attend a half-day "Personal Resilience" training course that was developed internally and explores energy, self-awareness, and purposeful living, says Kuhnen. Over the past two years, 18,000 employees have participated. "We have already seen increased engagement, job satisfaction, and willingness to experiment with new ways of working, plus decreased pressure from work-related conflicts," reports Kuhnen.

At Rochester, NY-based Xerox Corp., employees are given several tools to manage stress, including electronic tips, bulletin board materials, and newsletter and intranet articles, says **Sandi Alexander Tuttle**, manager of the Xerox Recreation Association. The information is pulled from a variety of sources, including the Wellness Council of America. "Additionally, we offer an on-line stress management course with personalized strategies to manage stress, regardless of the source of that stress," says Tuttle, who adds that the course was developed internally. Each year during open enrollment, employees are offered a \$200 credit to their benefit allowance if they complete a health risk assessment and, if someone scores high in the area of stress, they are encouraged to take the on-line stress program, says Tuttle.

The company also offers a LifeWorks program provided by Minneapolis, MN-based Ceridian, a workplace effectiveness service providing information and resources for a well-balanced life, says Tuttle. To inform employees about the programs, "health education leaders," a network of employees who volunteer to communicate wellness information, periodically receive fliers to

post, she adds.

In most of Xerox's large locations, on-site fitness facilities are provided so employees can participate in Yoga, Tai Chi, go for a walk or run, lift some weights, or participate in a group exercise class to relieve stress, says Tuttle. "Understanding the many ways our employees are stretched and stressed, and making these programs available, is well worth the resources necessary to do so," she says.

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Coalition takes on transition-of-care gaps

The National Transitions of Care Coalition (NTOCC), a coalition of 27 multidisciplinary stakeholders led by the Case Management Society of America (CMSA), has drafted a policy statement setting out problems stemming from transitions of care and outlining recommendations that can be taken by the health care industry and policy makers to improve transitions and patient care across the continuum.

"The development of these critically needed

tools represents an important step in solving transitional problems," says **Cheri Lattimer, RN, BSN, CMSA executive director.**

Transitions of care include situations in which a patient moves from primary care to specialty physicians or moves within the hospital, including moves from the emergency department to other departments, such as surgery or intensive care; or when a patient is discharged from the hospital and goes home or to an assisted living or skilled nursing facility. Patients, especially older ones, face significant challenges when moving from one level of care or practice setting to another. During these transitions, lack of communication can result in redundant or conflicting information that can create serious issues for patients, their caregivers, and their families.

CMSA and Sanofi-Aventis established the NTOCC in 2006 to address gaps in care that occur when patients, especially frail elderly patients, move from one care setting to another. ■

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CE questions

5. Patients who would be appropriate for VA Connecticut's telehealth program include which of the following:
- A. patients who live alone
 - B. patients who have a caregiver
 - C. patients at low risk for emergency department visits
 - D. none of the above
6. According to **Michael Culyba**, MD, UPMC Health Plan concentrated on members with the lowest access to care and the lowest HEDIS scores.
- A. True
 - B. False
7. For how many CPT codes did CMSA ask CMS to provide reimbursement?
- A. four
 - B. six
 - C. eight
 - D. 10
8. The Duke study found that hospice use reduced Medicare program expenses during a patient's last year of life by an average of \$500 per person enrolled in hospice care.
- A. True
 - B. False

Answers: 5. A; 6. A; 7. B; 8. B.

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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