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Covering Case Management Across The Entire Care Continuum

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IN THIS ISSUE

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Community-based case managers guide consumers through health care maze

Closer relationships mean more effective care plans

Faced with a complex, difficult-to-negotiate health care system, multiple providers, and myriad treatment options, many health care consumers are looking for somewhere to turn, and that means opportunities for case managers, says **Catherine M. Mullahy,** RN, BS, CRRN, CCM.

"Consumers pay for tutors for their children. They pay for legal advice and financial advice. Why wouldn't they be willing to pay for an independent professional case manager to be their advocate as they visit the doctor, to help them understand their treatment options and their medication and to help sort out the confusion," says Mullahy, president and founder of Mullahy & Associates, a case management training and consulting company.

Mullahy frequently hears case managers say they are discouraged by increasing paperwork that takes them away from direct patient contact. But while they are not satisfied with their jobs, they don't want to leave the field.

Community-based case management gives independent case managers the satisfaction of developing long-term relationships with their patients and allows them to balance their home life and their professional life, she says.

Getting back to the patients

"The process of case management works so well but you can't do effective case management when you have a caseload of 100 patients. Case management is so individualized and involves so many components. The best way is to put case managers in the community. When you can see a person in his own environment and develop a personal relationship with him, you can be a better advocate," she says.

Her words are echoed by **Susan Moore**, RN, PN, a Chicago-based

case manager who specializes in oncology and contracts with cancer patients and their families to support them through diagnosis, treatment, and survivorship.

"Meeting with people helps develop a closer relationship. The people I see personally think of me as a nurse case manager, advocate, and a friend. Those I work with by telephone see me as a nurse case manager and a resource, but the personal contact is lacking," she says. **(For details on Moore's case management experiences, see related article, pg. 27.)**

When Mullahy speaks at health care seminars and forums, she asks the nurses if they have patients who are readmitted to the hospital or visit the emergency department over and over again because of something that happens after discharge.

Regardless of the setting in which the nurses work, the answer is always "yes."

Discharge plan problems rampant

Patients are getting out of the hospital quicker and sicker but hospital discharge planners don't have the time to make sure that the discharge plan that looks great on paper really works, Mullahy says.

"Sometimes the patients are being treated by multiple physicians and they don't know which practice to call when they have symptoms. They call and get voice mail and the problem isn't corrected so they go to the hospital and are treated by yet another doctor," she says.

Chronically ill or catastrophically ill patients may be receiving telephone calls from a case manager, a disease manager, a health coach, and a discharge planner, but they don't talk to each other and none of them know what's going on in the home or what issues or obstacles to adherence the patient may be facing.

"The health care system is broken. The process of case management is a wonderful process and it's not broken. What is broken is where and how case managers are being used," she says.

Mullahy recalls the words of a patient in the hospital coronary care unit where she started her nursing career.

"I was telling him how he needed to make lifestyle changes, to pace himself better, and to consider another job. He said, 'You have no idea what my life is like,' and he was right. You can't possibly know what an individual's life is like and help him or her make lifestyle changes until you have a relationship with them," she says.

Case managers can't determine whether their discharge plan will work unless they know what is going on in the home. Is it in a trailer park or the inner city; is it crowded and dirty? All of those factors can affect the discharge plan and the patient's ability to adhere to the treatment plan, she says.

"I remain convinced that the best way to do case management is on site," she says.

The on-site model

The model is already working with geriatric case managers who help manage the care of

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Editorial Questions

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elderly patients whose children are living in other parts of the country, Mullahy says. Many geriatric case managers are social workers but there are many elderly people with complex conditions who could benefit from the help of a nurse case manager, she adds.

"You can't work with elderly Medicare patients over the telephone. You have to see them up close and personal to determine what is wrong. Some have dementia. Some have personal problems. Many have hearing problems. You can't work with them telephonically and you can't expect them all to use a web site to obtain the answers to the questions they may have or get the reassurance they need," she says.

Some insurance companies are beginning to provide face-to-face interventions for their high-risk clients. For instance, WellPoint locates community resource centers in areas where there is a large population of members in its publicly financed insurance programs in order to better serve its members by building a relationship.

"We realized that we couldn't adequately serve members' complex medical and social needs with just a toll-free number. With people whose needs are so complex and far-reaching, it takes a personal relationship to make a difference," says **Nancy Atkins**, MSN, RNC, NP, vice president of state-sponsored business for WellPoint. **(For details on WellPoint's programs, see related article, pg. 29.)**

But the elderly and other publicly funded clients are not the only people who could benefit from an independent, community-based case manager, Mullahy adds.

People who are catastrophically ill, people who are newly diagnosed with cancer, those with life-changing illnesses such as congestive heart failure or end-stage renal disease, parents of children with multiple handicaps or chronic illnesses could all benefit from someone who could help them understand their condition, evaluate treatment options, and help them comply with the treatment plan, she says.

"The goal would be to empower patients and families to become their own case managers. Some people may need only a few weeks of help until they understand what's going on. Others may need case management for several months," she says.

In addition to patients and family members, sources of referrals for community-based case managers may be treating physicians, Mullahy points out.

"As the trend toward giving physicians pay-for-performance incentives continues, some physicians are hiring case managers to help them improve the outcomes for complex patients. There is more recognition that complex patients need a different kind of intervention," she says.

Sources of referrals could include physicians who have difficult-to-manage patients, financial advisors who work with trust funds on behalf of individuals who suffered birth injuries or life-altering injuries from accidents, employers that offer health savings accounts, or self-insured employer groups not large enough for a managed care case management program.

"There's a push toward consumer-driven health plans and consumers assuming control of their health care but the system we have is not one that works for the average person. Of equal concern, the system is difficult even for those of us who have worked in the midst of it for all our professional lives. Patients and their families need someone to advocate for them and to help them through the health care maze and the community-based care managers can be that caring professional," Mullahy says.

*(For more information, contact **Catherine M. Mullahy**, Mullahy and Associates, Huntingdon, NY. E-mail: cmullahy@mullahyassociates.com. Web site: www.mullahyassociates.com.)* ■

Oncology CM helps clients with treatment, survivorship

Practitioner contracts with patients, families

Working from her Chicago home, **Susan Moore**, RN, NP, uses her expertise gained from years as an oncology nurse practitioner to help cancer patients and their family members explore treatment options, advocate for them through the continuum of cancer care, and support them whenever they have a question or a concern.

"Today's cancer treatments are very complex, with multiple options and choices and new treatment regimens coming on the market almost every day. As a case manager, I help patients with whatever needs they have, whether it's choosing the right treatment option, helping ensure their medical needs are met, or just being there when they need someone to talk to," Moore says.

Moore was a nurse practitioner in the ambulatory clinic of the department of hematology and oncology at Rush University Medical Center in Chicago before she started her independent practice. Most of her patients are referred by an oncologist or an oncology nurse and about 60% of them live outside of Chicago.

Patients or their family members pay for Moore's services, usually on an hourly basis.

Insurance does not pay for Moore's services, although she has been hired by insurance companies to provide case management for difficult cases.

"Some insurance companies don't have a nurse case manager or anyone on staff who is experienced in oncology. They use me as a consultant," she says.

Patients on the lookout for independent CM

Many of her patients are newly diagnosed with cancer and want someone to guide them through the treatment maze or those who need support during active treatment.

Some clients want a second opinion and don't know where to go or are having problems getting an appointment. In some cases, the physician who referred them doesn't have the support staff to do the legwork or doesn't know who to call for a particular diagnosis, Moore says.

"I have been in oncology for a long time and know people all over the country. I know who to call for particular cancers. For instance, breast cancer is a more aggressive disease in young women and I can recommend doctors who specialize in treating younger patients," she says.

Other clients have received a second opinion that is in conflict with the first opinion and want help sorting them out and choosing the best options, and others have cancer that has spread and want to explore clinical trials.

"There are numerous clinical trials being conducted in a variety of settings but community physicians don't always know about all of them nor have the time to research them on the Internet. A case manager can advocate for patients whose disease has spread and who need access to these kinds of trials. I can recommend a place for a second opinion and will go with the patient if they feel they need a medical professional to help them through the appointment," she says.

Some of her clients are women with strong family histories of breast or ovarian cancer who want advice on where to go to be monitored. These typically involve one or two consultations, Moore says.

When Moore gets a referral, she talks to the potential client on the telephone and explains her services. There's no charge for the initial call but if the patients do decide to contract for Moore's services, she starts charging fees after the initial call and when a contract is signed by the client.

If patients are within 100 miles of her home, Moore sets up a face-to-face meeting at their home or another convenient location. Subsequent contacts may be by telephone, e-mail, or in person, depending on the situation.

Not every referral ends up in a face-to-face relationship, Moore says. Some consultations are conducted strictly by telephone or e-mail, if the patient isn't in the Chicago area.

"When I have the opportunity to meet the patient and family members, it's helpful when other issues come up because I know what I'm dealing with in terms of family, friends, and other support," she says.

With patient consent, Moore arranges to have copies of the patient's records sent to her, reviews them, and talks with the physician to find out more information.

All in a day of a consulting CM

Moore follows her patients through their treatment regimen, supporting them in person or by phone or e-mail at regular intervals and advocating for the patients when they need them.

For instance, she makes sure that the patients are receiving appropriate medication to help manage the side effects of chemotherapy. She negotiates with the insurance companies if they won't cover the patients' recommended treatments or supportive care.

If a patient who is undergoing treatment has health-related or treatment-related problems at work, she mediates with their employer to make sure that job accommodations that qualify under the Americans with Disabilities Act are met.

For instance, one client was advised by his doctor to take a leave of absence from his job as a special needs teacher because his compromised immune system would make him vulnerable to infections he might be exposed to when he worked directly with the children.

The client told Moore he had to keep working because he was the primary breadwinner in the family and the limited disability income would

be insufficient to meet his family's financial needs.

She was able to intervene with the employer and have the client transferred to a counseling position for the duration of this therapy.

"My job is to oversee treatment and make sure the patients are referred for clinical trials, ensuring that they get the correct sequencing of care and that their supportive care needs are being met. I work with them on disability issues and make sure the insurance companies are reimbursing for the kind of care the patients need," she says.

Often, she's asked to accompany patients when they go to the doctor for a second opinion and to explain the options in a language that laypeople can understand.

If the patients live out of town, Moore is willing to travel to meet them as long as the patient pays for travel expenses and time involved for the visit.

In one instance, she made bi-weekly trips to Jacksonville, FL, to oversee an elderly woman's chemotherapy treatments for metastatic colon cancer. She sat with the woman during the treatments and stayed overnight in a nearby hotel until she was sure the woman wasn't having side effects from the treatment. She was hired by the patient's children, professionals in the Chicago area who couldn't go to Jacksonville every other week.

With years of experience in working with oncology patients, Moore can sometimes see issues that the nurse or doctor who is caring for the patient might not see because they don't have the time to spend with the patient.

"If I see a situation where symptom management could be better, I make a phone call to the nurse, tell her what I observed and make suggestions. Having a case manager on the job adds another person who is watching over the patient and looking out for them," she says.

The same is true with physicians and office staff, she adds.

Often, oncologists are too busy and concerned with clinical issues to give patients the emotional support they need, Moore points out.

"The nurses in the infusion center do listen and provide support to the patients but they're overwhelmed by a high patient volume as well and they may not be able to take a telephone call at 9 p.m. from a patient who primarily needs reassurance," she adds.

*(For more information, contact **Susan Moore**, e-mail: susan.moore@cancerexpertise.com.)* ■

Resource centers offer face-to-face support

Staff build relationships with Medicaid recipients

It's not unusual for Medicaid recipients to walk into one of WellPoint's community resource centers and ask for help in getting an appointment with a provider, arranging transportation or child care for a medical appointment, or to find out information about a chronic condition.

WellPoint's 22 community resource centers in seven states enable the health plan's multidisciplinary staff to build relationships with its members and to work community agencies to help meet members' needs.

"We know that the Medicaid population has complex lives and so many challenges that developing a trusting relationship is an important part of getting them to adhere to their medication regimen and their treatment plan. Having a presence in the community allows us to develop trust and break down some of the barriers," says **Nancy Atkins**, MSN, RNC, NP, vice president of state-sponsored business for WellPoint.

The state-sponsored business division serves members with low incomes or high-risk medical conditions who are eligible for publicly funded insurance.

WellPoint's community resource centers have diverse staff who match the demographics of the community. For instance, in areas with a large Hispanic population, the staff include employees who are fluent in Spanish as well as English.

"We help members in a lot of different ways in addition to their health care needs. We work with community organizations to help the members find help with housing, job placement, childcare, and other needs. We partner with community agencies and serve on their boards so we will know where the resources are to help meet all the needs of our members," she says.

To raise awareness of its services in the community, WellPoint offers classes at the centers, makes their conference room and meeting rooms available for community meetings, and maintains a group of computers that residents may use to access the Internet.

The staff at the community resource centers work as a team to help members learn to navigate the health care system and work to remove barri-

ers to compliance, whether the member needs education about a condition or assistance with child care, transportation, or housing.

The company brings together staff from all the community resource centers once a year to share best practices and learn new skill sets.

The staff at most centers include clinical quality nurses who provide clinical care coordination, outreach specialists who can help members find community services, health promotion consultants who conduct education for members and the community, and nurse case managers who coordinate the care of members with complex needs.

The outreach component

The services that the community resource centers provide goes beyond traditional health plan coverage, Atkins says.

Recently, a teenage boy who was covered by a WellPoint health plan for Medicaid beneficiaries walked into the insurer's community resource center in his neighborhood and asked for help. His mother, who was preparing for a bone marrow transplant as part of her cancer treatment, was in an isolation unit at a university-based hospital in a distant city and the boy wanted to see her.

The outreach specialist at the center worked with the hospital to set up a time for him to visit, set up transportation, and arranged for him to stay at a Ronald McDonald House.

Members receive an outreach call when they join the plan, educating them on all of the benefits that are available to them and urging them to call or come into the center if they need help.

The medical management and pharmacy departments analyze claims data regularly to identify members who haven't filled their prescriptions, who are newly diagnosed with a chronic condition, or whose claims data indicate a problem.

Providers often call the resource center if a member misses an appointment or hasn't brought her baby in for a well child visit and immunizations.

"Those are the red flags that indicate that someone needs an outreach. The team works together to investigate what is going on," Atkins says.

The team starts by trying to contact the member using the address and telephone number in the files. If the member no longer is at that address or the number has been disconnected, they may contact a community agency that has worked with the member for help in getting an address.

The person who gets in touch with the member may be the outreach specialist, clinical quality nurse, or case manager, depending on the situation. If the health promotion consultant is going to be in the community for an educational activity, he or she may be the person who tries to locate the member.

Case management is a mix of telephonic communication and face-to-face visits. For instance, if an elderly person hasn't shown up for a doctor's department or gotten a prescription refilled and the team can't reach him or her on the telephone, a team member will go out to check on the beneficiary.

If a case manager is working with a mother whose baby isn't gaining weight, she may visit the home to find out what is going on.

"If we don't get a response, we may need to go out into the community and find out what is going on," Atkins says.

When members are hospitalized, the case management nurses work with the case managers in the inpatient setting to help members navigate the system and to ensure that their discharge needs are met.

Each community resource center has a unique community-based model designed to meet the needs of that community and to comply with the different benefit packages and eligibility requirements of each state, Atkins says.

"The vision for this program is for us to be a partner in the community so we understand and know our members and their unique needs," she says.

For instance, some states require case management for certain populations, such as those with pediatric asthma. In those cases, the community resource center staff conduct outreach to members in those targeted populations as well as work to meet the needs of members who ask for help.

Because obesity is a huge problem in West Virginia, the community resource centers in that state have implemented several programs, including a collaboration with Weight Watchers to provide services for members, worked with providers to raise community awareness of obesity, and trained providers to measure body mass index of their patients.

Last year, WellPoint opened 11 new commu-

nity resource centers, bringing the total to 22.

"Having a presence in the community helps us meet the needs of our members. An 800 number just doesn't work with this population," Atkins says.

(For more information, contact Leslie Porras, Wellpoint's public relations director, e-mail: Leslie.Porras@wellpoint.com.) ■

CM cancer program reduces readmissions

Proactive approach starts at diagnosis

A cancer management program helps Great-West Healthcare increase the quality of life and reduce the cost of care for people with cancer by providing support throughout the diagnosis and treatment process for patients and their family members.

The Greenwood Village, CO-based health plan began its program in 2003 in response to increasing cancer treatment costs, rapidly changing cancer treatment protocols, and variations in standards of care in different parts of the country.

"We did a number of analyses on claims data to see where case management could have a potential impact. Cancer was one of the conditions that rose to the top where we could make an impact not only clinically but from a humanistic standpoint," says **Mike Norris**, vice president for medical management programs at Great-West Healthcare, which serves as a third-party administrator for about 6,000 employer groups and offers re-insurance for many of its clients.

"The employer groups we contract with have employees all over the country who are diagnosed with cancer. We want them to all get care according to national standards but physicians in different parts of the country may practice medicine very differently. The program ensures that our members' benefits are utilized appropriately and that they are getting standard care," Norris says.

In the first year of the program, the rate of hospital readmissions for Great-West members with cancer fell by 17%. About 87% of members enrolled in the program reported being "highly satisfied" with it on member satisfaction surveys.

Great-West partnered with the Matria Healthcare Oncology program, formerly known as Quality Oncology, a disease management company specializing in managing care for cancer patients to create the cancer management program and rolled it out in 2003.

"When we partner with vendors, we require that the program be completely branded for Great-West Healthcare. All of our vendor partners have to feed information into our system or use our software system so we can assure continuity of care," Norris says.

The case managers are nurses with experience in oncology. They create an individual management plan based on the type of cancer, the site of the cancer, the stage of cancer, the age of the patient, and other factors.

In addition to identifying members through claims data, Great-West has trained all of its employees who talk to members on the telephone to identify people with cancer. For instance, the customer service representatives are trained to listen for specific words that may indicate that a member has cancer and to refer that member to the cancer management program.

"Historically, we pick up a diagnosis of cancer once the claim comes in but we see real value in getting involved with the members as soon as their cancer is diagnosed, rather than when they have a claim for treatment," says **Joel Slaten**, manager of disease management for Great-West Healthcare.

For instance, if a member calls customer service to find out if a biopsy is a covered benefit, the customer service representative can refer the member to the cancer management program.

"This gives us an opportunity to be proactive and engage the members in the program and make sure their treatment protocol is based on national clinical standards.

"Most importantly, when people hear the word 'cancer' they are frightened and have a lot of questions. It is much more beneficial for them to have access to a nurse case manager at the beginning to help them make treatment decisions," Slaten says.

When the health insurer identifies a member with cancer, the staff first make sure that the member is eligible and that the employer group participates in the cancer management program.

Then the case manager verifies the diagnosis with the physician and finds out what the physician has told the member.

"Sometimes the spouse doesn't want the

patient to know that he or she has cancer or the extent of the disease. It's very important to understand how to approach an emotionally charged subject," Slaten says.

The oncology nurse case manager calls the member and explains the benefits of the program and sends the member information about the specific cancer. About 99% of eligible patients participate in the program.

"We work with the doctor on the care plan and look for alternatives for some of the expensive agents used in the treatment of cancer," Norris says.

The case managers educate the members about their disease and help them come up with questions that they need to ask their physician.

Contacts avaiable 24/7

The members are assigned a specific nurse and have access to his or her direct line. When the nurse is not on duty, the patient or family members can call a nurse line 24 hours a day if they have questions or concerns. Great-West sends a magnet to members in the program with an 800 number the member or his or her family can call 24 hours a day.

"We urge members to call the nurse when they are having symptoms. Often the nurse can help alleviate the situation without the member going back to the hospital," Norris says.

For instance, if a patient has chemotherapy on Friday and feels nauseated on Saturday, the nurse on the 24/7 line can pull up the patient record and see the discharge plan, then stay on the telephone while the patient drinks water to get rehydrated.

"We help the patients avoid the emergency department or an inpatient stay. The hospital is the last place you want to be when your immune system is compromised," Norris says.

One big benefit to the program is that patients can call a nurse with special training in cancer management at any time, even if they've just had a bad day and want someone to talk to.

"People can't do that with their insurance company or their doctor's office. Once the patient has established a relationship with the nurse case manager, the services are there for the whole family," Slaten says.

The nurses are trained in psycho-social management and can help patients and family members talk through any issues they may have. For instance, they may talk to a child who is afraid because his mother has lost her hair.

"We get tons of letters from people who have participated thanking us for the program. It makes a huge difference when someone has cancer and is afraid and just wants someone to talk to. They don't want to bother their physician with questions and problems but they can call the nurse for help and support," Slaten says.

When a member has surgery, the nurse case managers from the health plan follow them through the surgery, working with the hospital's case managers on utilization management. They call the patient after discharge and make sure home care services are in place and that recovery is doing well.

"We feel it's very important to have just one nurse during the entire episode of care," he says.

Primary nurse model

Great-West operates on a primary nurse model so that the member talks to only one nurse case manager at a time.

The health plan has established a hierarchy of disease, based on industry research. For instance, no matter what other disease a member may have, if he or she has end-stage renal disease, a renal disease specialist is the primary case manger.

Cancer is the next disease in the hierarchy. This means if a member is diagnosed with cancer and has diabetes or back pain or is pregnant, the oncology nurse is the primary contact.

"If a member has diabetes and is being managed by a diabetic nurse and a biopsy comes back positive for breast cancer, the oncology nurse takes over the case. They may have a three-way conference call between the member, the oncology nurse, and the diabetic nurse to share information. The member can always call the diabetic nurse but the oncology nurse is the primary case manager," Norris says.

Once the patient completes treatment, the diabetes nurse takes over again.

The program focuses on people who are in active cancer management, those who are newly diagnosed, being worked up for a bone marrow transplant, receiving chemotherapy or radiation. People stay in the program for five to seven months on average.

About 45% of people who have had cancer are in active cancer management at any given

time, Norris says. "We keep the other 65% on our radar screen but do not provide direct support," he adds.

*(For more information, contact **Michael Norris**, vice president for medical management at Great-West Healthcare, e-mail: michael.norris@gwl.com.)* ■

These interventions may help night shift workers

Promote good sleep and dietary habits

With evidence mounting of links between serious medical conditions and night shift work, you should evaluate your shift work policies and practices to make sure they adhere to recommended best practices, such as minimizing schedule disruptions, says **Robert Emery**, DrPH, assistant vice president for safety, health, environment, and risk management at the University of Texas Health Science Center at Houston.

"There are several well-known issues inherent to shift work," he says. "You might as well take this opportunity to make sure you're addressing those, while other investigations in this issue play out."

Actively communicate with workers through newsletters and other correspondence to make them aware of the study, its limitations, and the need for more controlled studies; then provide reminders about suggested healthy habits, advises Emery.

The linking of night shift work to cancer is now one more problem occupational health professionals will have to address, without being able to control the lifestyle or dietary decisions of employees, says **Kathy Ohlmann**, RN, MSN, COHN-S, a sleep educator at Work Place Solutions, a Louisville, KY-based company specializing in health and safety concerns in the workplace. Your job is to provide employees with a safe working environment based on the latest research and information available, says Ohlmann. The rest is the employee's job, she says.

It's not known whether the night shift employees diagnosed with cancer followed healthy lifestyle choices, such as getting more than a few hours of sleep during their off time or eating healthy foods, says Ohlmann. "The role of the occupational health professional is to balance the good of the company with the safety and well-being of the employee," she says. "Sometimes that's a real difficult balancing act." Ohlmann recommends these interventions for occupational health professionals:

- Perform an ongoing evaluation of the benefits of night shift work to the company, and assess the impact on employee health.
- Monitor the health status of employees, and promote wellness programs with preventive screenings for all employees, including those on the night shift.
- Promote healthy food choices around the clock in vending machines, cafeterias, and break rooms.
- Educate employees on the importance of sleep, the effect of sleep deprivation on the body, and alternate ways to protect the needs of the body when sleep is altered. "This should include the families of those affected, as well, since it's a lifestyle to work other than dayshift," Ohlmann says.
- Assess the impact of work shift scheduling on safety, health, and productivity.

The effect on an individual employee from working nightshift varies widely depending on many variables, such as length of shifts, number of shifts worked before a rest day, and number of rest days and weekend shifts, says Ohlmann.

Other considerations are the amount of rest taken between shifts, the amount of rests during shifts, and the regularity and predictability of the schedule, she says. "All of these factors can affect the amount of stress and fatigue the individual feels because of the work schedule," says Ohlmann. "If people experience added stress and fatigue, they may not do the job safely and efficiently, or they may develop health issues." ■

Treatment may help workers with arthritis

Workers need accommodations, rarely get them

Treatment with a tumor necrosis factor (TNF) alpha blocker may help keep workers with rheumatoid arthritis (RA) employed, at least those with disease duration of 10 years or less, says a new study.[1]

"Initially, we didn't find any effect in use of

those drugs in helping people maintain employment; but in further analyses, it does look like it helps people with shorter disease duration stay employed," says **Saralynn Allaire**, ScD, the study's lead author and a researcher with Boston University School of Medicine.

The reason the medication might not help people with longer duration is that some of the effects become permanent, and no new treatment can offset those changes, says Allaire.

It's been known for a long time that people with rheumatoid arthritis who stop working do so in part because of the type of work that they do, which is generally physically demanding, says Allaire. For this reason, it's key for occupational health nurses to offer accommodations to these employees, she stresses.

Typically, people with arthritis don't consider themselves disabled, and may not realize that they have the right to ask for accommodations, says Allaire. "Instead, they tend to cut back and go part-time," she says. "But studies suggest that's not an effective solution to help people maintain employment. Instead, it's sort of a marker of exit from the workplace, and people become less committed to working."

Employees with musculoskeletal conditions, including rheumatoid arthritis, hardly ever receive accommodations, adds Allaire. "They are reluctant to ask for them, because then they have to disclose their condition. There is a lot of fear about that," she says. "Then people get upset with their coworkers because either they need help but don't ask for it, or in some cases, they ask for help and don't get it."

Under the Americans with Disability Act, employers can't reveal the condition to coworkers without permission, but resentment may occur if there is no explanation about why a worker is receiving accommodations, says Allaire. "People worry about that upfront, which is one reason they don't ask for accommodations in the first place," she says.

Since early rheumatoid arthritis is not a very visible disease, employees may have a lot of pain and stiffness that their coworkers can't see, says Allaire. "Sit down with the employee and discuss issues of working with other people. Then make a plan of action for what to do," she says.

Reference

1. Allaire S, Wolfe F, Niu J, et al. No evidence of reduction in premature work loss among persons with rheumatoid arthritis (RA) using anti-TNF alpha agents. *Arthritis Rheum* 2007; 56:S806. ■

Plan STD educational outreaches for April

Best target audience is teens and young adults

"There are about 19 million new cases of sexually transmitted infectious diseases each year in the United States, and they don't just happen to people who are promiscuous or reckless. They can and do happen to anyone. Even folks with few partners, even people who consistently use protection can still be at risk for a lot of STIs [sexually transmitted infections]," says **Fred Wyand**, media and communications manager for the American Social Health Association (ASHA) in Research Triangle Park, NC.

That is why the association has declared April National STD Awareness Month. Getting the magnitude of the problem out to the public is important, Wyand says.

There are other issues that need to be addressed. There is a need for safer sex practices, such as condom use, even if both partners look and feel fine. He explains the absence of symptoms is not a good indicator of whether someone may have been exposed to an STD that can be passed to a partner.

People need to be proactive in talking about sexual health with their physicians, nurses, and other health care providers, adds Wyand. While these conversations are awkward, they should be encouraged because this is a good way to determine if testing is recommended, he says. The Centers for Disease Control and Prevention recommends all sexually active women below the age of

25 be tested annually for Chlamydia, a genital infection frequently found in sexually active adolescents and young adults. Wyand says research shows most people aren't tested for Chlamydia until age 30, even though the vast majority of infections are found in younger people.

"Women can have Chlamydia and not even know they have been exposed to it until the infection starts to spread and they begin to have problems. That is why having conversations with health care providers is important," says Wyand.

There are a few stumbling blocks to effective education, however. Wyand says there is stigma to having an STD, so it is important to normalize the discussion by making sure people understand that it is a massive problem. Having an STD does not mean a person did something wrong or let his or her guard down. "No matter what, a person can be at risk," says Wyand.

Lack of access to health care in poor communities also is a barrier to education, diagnosis, and treatment of STDs. Wyand recommends providing a list of free or low-cost clinics along with education about STDs to address this issue.

Targeting the right populations

When designing an outreach for National STD Awareness Month, consider how to reach the patient population most in need of education, advises Wyand. About half the new cases of STDs in the United States each year occur in people under the age of 25, so teens and college-age students are more likely to be impacted.

Comprehensive sexual education messages are important, says Wyand. Start with abstinence as the best way to prevent an STD but discuss prevention tools for those who are sexually active. Talk about how valuable condoms can be if used consistently as well as limiting the number of sexual partners. Safe sex practices include having only one sexual partner.

Another target audience would be poor communities because many who live there lack health insurance and access to affordable, convenient care.

"If you are not able to be tested and treated, it can become a vicious cycle for there is a greater likelihood of complications from untreated STDs such as Chlamydia, which can spread to a woman's upper reproductive tract if not treated and lead to infertility and chronic pelvic pain," says Wyand. According to Wyand, research is increasingly showing that people who have one STD are more likely to contract another if exposed. This includes HIV.

Presenting clear facts to dispel misinformation is important. Wyand, who has 10 years experience as a sexual health educator, says when he was in college he was aware of STDs but expected he would have symptoms if he had contracted one.

Providing resources is helpful as well. In addition to a list of free or low-cost clinics, compile a list of health web sites that target various patient populations such as men, women, and minorities. A good place to begin this research is the ASHA web site (www.ashastd.org), which has links to sites focusing on herpes, HPV, HIV/AIDS, sexual health, condoms, teens, and more.

Also encourage people to have clear communication with their physicians and their sexual partners. A message board on the ASHA web site provides an opportunity for people to anonymously ask questions, interact with others who have an STD, or just observe to see how others are coping.

"The best way to observe the month is through education because that leads to empowerment and reduces the stigma and embarrassment factor," says Wyand. ■

COMING IN FUTURE MONTHS

- Proving the value of your case management department
- Integrating case management and disease management
- Culturally specific disease management techniques
- Strategies for eliminating emergency department frequent flyers

CNE questions

9. **Catherine M. Mullahy**, RN, BS, CRRN, CCM, says the community-based case management model is already proving successful in the pediatric population.
   A. True
   B. False

10. Case manager **Susan Moore**, RN, NP, does which of the following as part of her work with patients?
   A. ensures patients are taking the right medications to manage side effects from chemotherapy
   B. negotiates with insurance companies
   C. mediates with patient's employer
   D. all of the above

11. How many community resource centers does WellPoint manage?
   A. seven
   B. 12
   C. 20
   D. 22

12. There are about 19 million new cases of sexually transmitted infectious diseases each year in the United States.
   A. True
   B. False

Answers: 9. B; 10. D; 11. D; 12. 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. ■

CNE instructions

Nurses 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 the **June** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■