Case Management ADVISOR™

*Covering Case Management Across The Entire Care Continuum*

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## IN THIS ISSUE



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# Protect yourself from lawsuits, allegations of fraud and abuse

*Complete documentation, malpractice insurance are essential*

In today's litigious society, it's important for case managers to understand the laws and regulations that affect their practice and to protect themselves against lawsuits and allegations of fraud and abuse.

"The role of the case manager is becoming more and more important and more and more clear as time goes on. Our society is not getting any less litigious and there is no doubt in my mind that case managers may be included in lawsuits," says **Elizabeth Hogue**, Esq., a Washington, DC-based attorney specializing in health care issues.

Case managers can be at risk for legal action if the plan of care they develop doesn't meet the patient's needs, is incomplete, or if the patient is referred to a provider that cannot provide appropriate care, she says.

"National standards of care make it clear that case managers are responsible for taking appropriate steps to help ensure that patients receive appropriate, cost-effective care," she says.

Accurate and complete documentation is crucial to avoid fraud and abuse charges and to manage risk from lawsuits, Hogue says.

Keep in mind the saying: If it wasn't documented, it was not done. Make sure that everything you do is fully documented in the patient record, she adds.

This will protect you from charges of submitting false claims as well as the potential for medical malpractice lawsuits, she says.

"The Office of the Inspector General [OIG] of the U.S. Department of Health and Human Services has repeatedly stated that providers carry the burden of proving that care was actually rendered to patients," Hogue says.

If practitioners can't show that they rendered appropriate care for which they submitted claims, because it was not documented, fraud enforcers, such as the OIG, may conclude the claims submitted by the providers are false, she says.

In addition to large fines, submission of false claims can include sus-

pension or exclusion from participating in Medicare and Medicaid programs and other federal and state health programs.

Providers also run the risk of negligence or malpractice when they fail to document the care provided, Hogue points out.

This is particularly important when case managers or other providers make recommendations to patients that they reject and neither the recommendation nor the refusal is documented, she says.

Hogue cited a lawsuit in which Joseph Lee Amos sued Rebecca L. Crouch, MD, and her malpractice insurance company, Louisiana Medical Mutual Insurance Co., claiming that Crouch breached applicable standards of care when she failed to recommend and conduct diagnostic testing indicated by Amos' symptoms of bleeding after bowel movements. Amos sought a second opinion from a physician who diagnosed him with colorectal cancer.

The lawsuit claimed that Crouch's breach of standards of reasonable care caused a delay in diagnosis or treatment of his cancer.

Crouch argued that she had recommended appropriate tests to Amos but he refused. However, since she had not documented her recommendation or his refusal, the court concluded that it could not reasonably conclude that Crouch had made the recommendations.

"If case managers don't document what they did in terms of making appropriate referrals and appropriate management of the patient's case, they could find themselves in the same boat," Hogue points out.

The same situation could be applied to case managers in the insurance industry, she says.

If a case manager or disease manager recommends a treatment plan to a patient or suggests a particular service, it should be thoroughly documented in the record, she says.

It is essential to correct or supplement patient records after the fact if a retrospective review reveals incomplete or inaccurate records, Hogue says.

"The records must be corrected or supplemented in order to help ensure quality of care, meet applicable regulatory requirements, and avoid allegations of fraud and abuse," Hogue says.

The record may be corrected if the clinician has a clear recollection of the information or there is a written record that serves as the basis for the clinician's supplement or corrections, she says.

Hospital and provider case managers may be called to correct the record if a retrospective review reveals incomplete or inaccurate records.

The same is true of case managers in the insurance setting, Hogue says.

For instance, if a retrospective review shows that a member's case management services were terminated and the record doesn't reflect the reason, the file should be amended to include documentation as to why the company is no longer providing case management services, she says.

Supplements must include the date the entry is made, the information that was originally omitted, and the date on which it was available, along with the signature and title of the employee who

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supplemented the record, Hogue says.

"Corrections must be made by drawing a solid line through the mistakes. Providers' internal policies and procedures may also require the staff to write the word 'error' in relation to the information through which a line has been drawn," she says.

Clinicians must not use correction fluids or make erasures when correcting the record, she advises.

### Purchasing your own insurance

Purchasing your own malpractice insurance can provide peace of mind at a relative low cost, Hogue says.

"I believe every case manager should have his or her own malpractice policy. It's not so expensive that it's prohibitive. Case managers may think they don't have any assets; but they have a home, an automobile, and a savings account and they could lose those if they are sued," she says.

Hogue recommends that case managers purchase malpractice insurance even if they are covered under their employer's policy.

When claims are filed, your employer's insurance company will assign legal counsel to defend the claims. The legal counsel clearly represents the employer, not necessarily the employee, which in this case is the case manager, Hogue says.

"In fact, if legal counsel determines that actions a case manger took are outside the scope of employment, the malpractice insurance company may decide there is no coverage for the claims filed against the case manager. Under these circumstances, the only insurance case managers may have is the coverage they purchased," she says.

If you purchase your own malpractice insurance and a claim is filed against you, your insurer will assign legal counsel, which will represent your interest.

In some instances, multiple claims may be filed against the same provider and may exceed the liability of your employer's insurance policies. This also means that the only coverage you have is what you purchased yourself, she adds.

There's a misconception that if a case manager has malpractice coverage he or she is more likely to be sued, Hogue says.

"This is not true. In most instances, patients and families have no way of obtaining information about whether or not you have malpractice insurance before lawsuits. Even after a lawsuit is filed, discovery may prohibit attorneys for the plaintiffs from getting information about malpractice insurance," she says. ■

# Focus on preventive care pays off for health plan

*Program rewards staff, members for HEDIS measures*

By using state-of-the-art technology to ensure that members receive preventive care measures and rewarding staff, physicians, and members when the preventive services are rendered, Health Plan of Michigan has increased its membership dramatically and is ranked No. 10 among the Nation's Best Health Plans by *U.S. News & World Report* and NCQA.

The ranking is based on the health plan's achievements in preventive care, appropriate treatment, and customer satisfaction, and is largely based on the health plan's scores on the Healthcare Effectiveness Data and Information Set (HEDIS) performance measuring tool administered by NCQA.

"We believe that ensuring that members get more care, rather than less care, saves health care dollars in the long run. Our mission is to reach out to every member to educate them about necessary preventive services, which keep them healthy and out of the hospital," says **Thomas L. Lauzon,** executive vice president and chief information officer of the Detroit-based health plan.

The plan was founded in 1997 with four employees and 800 members in one Michigan county. This year, it has 125 employees and 146,000 members in 42 counties.

"What makes our health plan unique is our use of technology to make all our processes incredibly efficient and effective. All of the technology centers around our proprietary Managed Care System [MCS] technology system. No one needs to remember to send post cards or make outreach calls. Everything happens automatically through the system," says **David B. Cotton**, MD, president and CEO.

The health plan's technology system is designed around care management and quality of care, not claims processing, Lauzon says. It provides real-time information to health plan employees and providers, enabling them to see at

a glance whether the member has had all the recommended tests and preventive services. Any time a health plan staff member or provider accesses the member's records for any reason, the computer system indicates with a red "H" if the member has not received one or more preventive services covered in the HEDIS measures.

"Anybody who touches the member is aware of whether the member needs preventive services. Preventive care saves lives and helps our bottom line," Lauzon says.

For instance, if a member calls the member services department to change primary care physicians and the staff member notices that a child is missing an immunization, the system generates a script that the staff use to explain why the immunization is necessary. If the member has a problem getting to see the doctor, the health plan staff offer to set up free transportation or schedules the appointment for the member.

Then, 90 days later, if a claim for the missing immunization hasn't come in, the member hasn't received the immunization, the information about the missing services goes back into the record for the member to be contacted again.

As claims come in and HEDIS measures are satisfied, the system is updated in real-time.

"Everything in our system is integrated. Claims data, membership information, HEDIS data, and provider information are available to everyone, including providers. When they pull up a member file, they can see automatically what preventive services the member needs to receive," Lauzon says.

All employees have the ability to earn sizeable bonuses if the health plan hits its goals for all HEDIS measures.

If the company exceeds the NCQA 50th percentile, each employee gets a bonus for that measure. If the figure rises to 75%, employees get a higher bonus. If the health plan ranks in the NCQA 90th percentile on a measure, the bonus increases significantly.

"All employees, including those in information systems, are responsible for our HEDIS scores. Our HEDIS graph tells us the goals and where we are at the moment. If we need one more person to hit a certain percentile, the staff start looking for that person and getting them the services they need. We've created a team environment where everyone in the company works to get the members the care they need," he says.

The company's new facility in downtown Detroit will soon have 40-inch computer monitors placed throughout the building that show the health plan's performance on HEDIS measures in real-time.

"No matter where staff are, our performance on the HEDIS measures will be right in front of them. We constantly remind our employees of how important these measures are," he says.

The health plan offers bonuses from $15 to $100 to providers on top of their normal Medicaid reimbursement if they take care of preventive services for members. When a physician's office logs into the health plan's managed care system, the same big red "H" appears if the member is missing one of the HEDIS measures.

Members also receive incentives for completing recommended preventive care measures. They include gift cards, gas cards, and phone cards. Last year, Health Plan of Michigan sent more than 3,200 incentives to members.

The health plan's outreach team makes welcome calls to new members and conducts a preliminary health risk assessment. If the mini-assessment shows that the member may be at risk, the member is automatically referred to case management using the health plan's information systems "to do" list to generate a reminder on the case manager's daily task list.

"The providers who treat our patients can see everything we can internally and they have the ability to add information to our system. For instance, if we don't have a member's diabetes listed, the doctor can enter the information and send a referral to disease management," he says.

In order to improve HEDIS rates by providing timely outreach messages to members, the health plan implements regular telephone campaigns on a daily basis to remind members of the tests and screenings they need.

Initially, every staff member made the outreach calls to members.

In 2006, the health plan implemented an automated dialing system integrated with its information system to maximize the number of outbound calls member services staff can make in a day and reduce the time staff spend on wrong numbers or no answers.

"The system increased our ability to reach members by 240% in one year. The staff made more than 108,000 telephone calls in 2007 to remind members of preventive services," Lauzon says.

After the system was implemented, the health plan's HEDIS scores increased by an average of 8.6 percentage points per HEDIS measure.

If a person answers, the member services representative talks to him or her about having the preventive measure. If an answering machine answers, the system leaves a message asking members to call. If they don't call back in a week, members receive another call.

The system is set up so that if claims data indicate a member who receives a reminder call hasn't received that preventive service in 90 days, the member is placed back in the system to be called again.

This system saves lives, he adds. For instance, one woman hadn't received a Pap smear for some time and received outreach calls and reminders from the health plan.

"She was resistant to seeing a gynecologist but she finally went because we kept calling her. She found out she had cervical cancer and was able to get treatment in time. Our outreach efforts saved her life," Lauzon says.

When members enroll, the health care system stratifies them according to their risk, using historical data provided by the state of Michigan.

Members who are most severely at risk for a health care event are referred to case managers who work with them to help them get their condition under control and become compliant with their treatment plan and medication regimen.

During the initial call, the case manager conducts a health risk assessment that helps him or her develop a plan of care.

"Our system ties in the subjective information from the health risk assessment with the objective information from claims data. Having comprehensive information on the screen helps the case manager work with the patient," he says.

When a member's condition improves, he or she is moved to disease management and receives reminders about recommended care and examinations. If their condition worsens, they are referred back to case management.

The health plan has accurate telephone numbers from about 40% of its membership, and concentrates on getting the other members' contact information up to date using various methods, Lauzon says.

"We realize that our members are a transient population and hard to reach. Our MCS is available to providers in all settings, including physician offices, emergency rooms, outpatient facilities, and hospitals. This gives us access to updated contact information through our authorization and claims systems," he says.

The plan has been successful in getting in touch with members by sending a letter asking them to call the health plan with updated information. It gets other telephone numbers through database services, physician offices, and vendors, such as diabetes vendors that provide supplies to the members.

"If we don't have a good number for a member, we don't waste the nurse case manager's time in trying to contact them. That member goes in the 'lost member' campaign until we get a number for them. Then they go back into case management," he says.

When members are at risk, the health plan case managers go the extra mile to see that they get treatment.

For instance, one member with diabetes, chronic obstructive pulmonary disease, and other comorbidities was hospitalized over and over but wouldn't follow up with her primary care physician or comply with her treatment plan.

The health plan paid for a home health physician to go to her house and assess her condition.

"She weighed 400 pounds and could hardly walk because she had a gangrenous infection in her foot," Lauzon recalls.

The patient was hospitalized, and then treated at home by a physician twice a week for a few weeks, followed by weekly visits from home health nurses and intensive case management.

"We kept her out of the hospital for over a year," he says. ■

# Program rewards members for good diabetes care

*Hospitalizations, emergency department visits drop*

UCare's diabetes disease management program that rewards Medicare Advantage members for receiving their recommended examinations and tests has resulted in a decrease in hospitalization and emergency room visits.

From 2004 to 2006, hospital admission rates among UCare's members with diabetes dropped from 2.76% to 1.11%. Over the same period of time, emergency department visit rates for diabetic members dropped from 2.76% to 1.74%.

"We have an intensive education program to keep our members with diabetes informed about best practices in diabetes care and to encourage them to manage their disease. In addition to our

efforts, our community has a lot of diabetes awareness activities, which may help influence the drop in hospital admissions and emergency room visits," says **Jodie Milner**, RN, BSN, manager of disease management.

Data from 2007 show that 31% of members who were stratified as "at risk," meaning they were missing one or more components of care, had improved to the point that they were reclassified as "low risk."

UCare modeled its Medicare Advantage diabetes program after a similar disease management program for Medicaid members with diabetes.

The health plan analyzes claims to identify members with diabetes and stratifies them as low risk or at risk. A member is considered low risk if he or she has had two hemoglobin A1c tests in a year, an annual cholesterol test, an annual dilated eye examination, an annual micro-albumin urine screening for kidney disease, and two well visits to a primary care physician or endocrinologist over the course of the year.

"Since most of the tests and examinations must be done once a year, we analyze data from members who have been enrolled with UCare for 12 continuous months," says **Lorraine Cummings**, LPN, disease management program coordinator.

All UCare members with diabetes receive educational brochures and newsletters about diabetes and recommended care as well as information about UCare's toll-free diabetes message line where they can ask non-urgent diabetes-related questions and receive a phone call from a nurse within two business days.

At-risk members also receive a customized diabetes care report that lists all of the laboratory tests and recommended visits along with the date of their most recent visit or screening. Copies of the report are sent to the members' primary care physicians.

The diabetes care report is accompanied by a voucher that the members get signed by their physicians and return to the health plan when they have completed all the tests and examinations. A completed voucher qualifies members for a gift card from Target.

Members also receive an additional voucher on which they fill in their hemoglobin A1c levels and their LDL cholesterol levels and return it for a Target gift card as well.

"The purpose of this voucher is to make members more aware of the laboratory tests they need and the necessity to get their laboratory values in control," Milner says.

Members who are up to date on all of their required examinations also receive a congratulatory letter and a reminder that they need to receive the same tests and exams over the next year. As an incentive for receiving the recommended care, the members receive a 100-minute phone card.

The disease management department receives utilization data on a daily basis that identify members with a primary diagnosis of diabetes who have had an inpatient stay or emergency department visit.

"We notify the patient's primary care provider of hospital stays or emergency room visits where diabetes is the primary diagnosis. Since some hospitals employ hospitalists, the primary care physician may not know that their patient has been hospitalized," Cummings says.

The health plan sends the physician a form with patient demographic information, information about the recent utilization, and a pharmacy profile that includes medication refills within the last two months.

"This enables the physician to determine if the member is filling his or her medication appropriately," she says.

The health plan is expanding its diabetes program to include an intensive case management initiative for high-risk members, says **Tracy Fodstad**, RN, PHN, BSN, complex care RN, who will be working with members who have been hospitalized or made an emergency department visit.

"We want to help the members overcome the barriers to getting their disease under control. It may be a case of helping the member identify a medical home and make regular visits to their primary care provider or coaching them on diet, exercise, or medication adherence," Fodstad says.

The health plan's case management department works with members who are seeing multiple physicians, take multiple medications, and have other complex needs.

The case managers work with them for a short period of time to coordinate their care, and then refer them back to the Medicare Advantage program.

The high-risk case manager program will target members who have been to the emergency department, had an inpatient stay, or whose laboratory values are outside normal parameters.

Some of the members are recommended to the program by physicians who feel that a patient

needs more intense support to get his or her disease under control. ■

# Patient education crucial for underserved population

*Education can lower costs, boost self-management*

Lack of access to health care can keep people from learning how to self-manage a chronic disease and how to appropriately use medical care to achieve good health.

To remedy this, some institutions have set in place ways for the underserved, uninsured, needy population to receive treatment and education. This includes Mount Carmel health care system in Columbus, OH.

The organization has created "health stations," fully equipped physicians' offices, within churches in the inner city of Columbus. The overall goal is to eliminate health disparities within minority populations.

"Our purpose is to promote healthy lifestyle choices, to sustain education interventions, and improve access to care as well as providing holistic health care," says **Jacquelyn Godfrey Hilton**, RN, director of health stations and church partnership at Mount Carmel Hospital.

Another program, "church partnerships," empowers people to take care of their own health. "We try not to be enablers but to educate and promote health in a way that the individual begins to take responsibility for his or her health," says **Rebecca Madine**, RN, coordinator for church partnerships.

At the Medical Center of Central Georgia in Macon, a full service clinic called the the W.T. Anderson Health Center serves those who cannot afford health care. Like Mount Carmel, serving the underserved is part of the organization's mission. The largest division at the health center is the internal medicine clinic where primary care providers and two nurse practitioners treat patients. The medical center is affiliated with a school of medicine so internal medicine residents make up most of the staffing.

It is in this clinic that people receive continuity of care for chronic diseases and health problems that need to be managed over time, says **Sandra Higgison**, RN, MSN, MBA, FACHE, director of ambulatory health services.

## The impact of education

These are examples of different methods of outreach to provide health care to the underserved. Patient education is an integral component of all of them.

Higgison says education helps keep costs under control. Education, by definition, is measured by a change in behavior and that is often key in the management of chronic disease, which can be costly.

Although the Anderson Health Center receives several forms of funding including patient payment on a sliding scale, grant money, and some state and county funds, this does not totally cover the operating costs.

Behavior change through education that results in good disease management will help reduce costs. Such change is often a slow process. Higgison says one of the biggest barriers to education at the Anderson Health Center is a patient's priorities, based on his or her value system. For example, many patients seen at the health center don't always make the purchase of medications a priority.

It is important to determine how to make behavior change valuable to the patient or determine how to fit good health practices into the patient's value system. Higgison says diet impacts a lot of chronic diseases and is the focus of many educational efforts. For example, patients are sent to diet classes. Many patients seen at Anderson Health Center eat a high-fat, high-salt, high-cholesterol diet.

## Working with outside groups

The partnership Mount Carmel forms with churches provides an opportunity to target the physical, emotional, and spiritual health of a congregation and its surrounding community through health promotion activities. Madine helps churches in the program form a health ministry team that assesses the needs of the congregation and community. This assessment is completed by direct observation and a written questionnaire, and the information is used to develop a plan along with intervention programs to meet the needs of the community.

Madine says Mount Carmel partners with churches in all types of communities regardless of socio-economic status because the one thing people have in common are health issues such as hypertension, high cholesterol, diabetes, and stress. However, in less affluent areas, it is impor-

tant to meet people's basic needs before doing a lot of education.

"Often, we work with food pantries, not only to provide food for the individual but to provide information about healthy eating and other disease conditions or concerns they may have," says Madine.

The congregation and community also are taught how to donate healthy items to food pantries.

Education does not focus on physical health alone but takes a holistic approach, providing classes on emotional issues such as grieving or dealing with a family member with Alzheimer's. Churches also are given a spiritual assessment tool to screen participants for spiritual distress, says Madine.

The education needs of patients who seek medical care at health stations often are met through the church partnership programs, says Godfrey Hilton**.** For example, people are connected to exercise or cooking classes. One-on-one education does take place as well as group education, she adds.

Higgison says at Anderson Health Center, many educational strategies are used. Literature is at a low reading level with lots of pictures to accommodate those who don't read well. Staff work with patients to not only educate them on a topic such as proper foods for people with diabetes, but to help them apply the information. For example, a nurse might help the patient review their favorite foods, selecting those that best fit a diet for a diabetes patient.

Sometimes people are more receptive if the message is delivered by someone who shares their culture. So this strategy is used as well, says Higgison. Group visits for people with diabetes are also in place so patients can discuss the lesson with one another.

Whatever the strategy, repetition is key, adds Higgison.

Health ministry teams in the faith community working with Mount Carmel are helped with their education efforts with written materials that fit the needs of the congregation. And they are given screening tools, says Madine. For example, if hypertension is a health problem, the church would receive a couple of blood pressure cuffs as well as literature on the topic. In addition, the health ministry team receives training in holistic health practices.

Team leadership can participate in a bi-monthly educational program where a health topic is covered, such as the prevention of infection in churches. Mount Carmel also produces a monthly newsletter, with information on health topics and programs and conferences in nearby communities, that is sent to church partnerships.

According to Godfrey Hilton, participation in education is higher if some sort of social aspect is added. For example, health screenings and education might be paired with a car show or information might be presented in the form of games or a contest.

The greatest barrier to education in the church partnership programs is literacy and language.

"We are always looking at providing education at the level of understanding of the person. Most of our printed education does that very well," says Madine.

In addition to low literacy materials, foreign language materials are also offered for those people who do not read English. People in the congregation are used as interpreters during education sessions.

Madine says time is sometimes spent in one-on-one education if people don't seem to understand what is being taught.

## *Multiple benefits*

There are many benefits to providing education and health services to the underserved and uninsured populations. Mount Carmel conducted a survey of participants in outreach programs and found that many did not receive regular medical care before being introduced to health stations. Those without regular care are often uncovered in the church partnership programs and referred to a health station.

"Most of the patients tell us the way they got medical care before was through the emergency room when they were in medical crisis," explains Godfrey Hilton.

Madine says that by working specifically with churches, the medical center is able to enter a relationship with people in an environment where they feel safe. "People don't always feel safe coming to the hospital or doctor's office but we know if we go to the church where they are comfortable and that is where their peers are, we are entering an environment where they feel more comfortable; they are more accepting of health education, health care, and health promotion in those facilities," she explains.

Whatever the program, it is important to stress

empowerment of the individual to take responsibility for their health, says Madine. ■

# Heart attacks decreased for non-smokers by 70%

*Results confirm hazards of secondhand smoke*

After a countywide smoking ban was implemented in Indiana's Monroe County, hospital admissions for heart attacks dropped 70% for nonsmokers, but not for smokers, according to a new study.[1]

Researchers compared 22 months before and after the smoke-free law was implemented, and found a 59% net decrease in hospital admissions for heart attacks in nonsmokers with no prior cardiac history, hypertension, or high cholesterol.

This shows the dramatic impact that a smokeless workplace can have on employee heart attack risk, says **Dong-Chul Seo**, PhD, CHES, the study's lead author and an assistant professor in Indiana University-Bloomington's department of applied health science.

"The results of my study confirm how hazardous exposure to secondhand smoke is," says Seo. "Occupational health professionals should use these research findings to advocate for a smoke-free workplace."

According to the American Nonsmokers' Rights Foundation, 12,559 municipalities are covered by a 100% smoke-free provision in workplaces, representing 62.8% of the U.S. population. A total of 26 states, Puerto Rico, and Washington, DC, have laws requiring 100% smoke-free workplaces.

"The study shows that strong smoke-free workplace laws result in immediate and significant improvements in heart health, particularly in nonsmokers," says Seo.

## *Give workers a long lead time*

Dallas-based Texas Instruments is currently evaluating the possibility of switching to a smoke-free workplace at five facilities in Texas and Arizona, covering 13,000 (85%) of its employees.

"We are in the process of building the business case and identifying the potential pitfalls and pros and cons of this, so we can present this to management and then proceed," says **Linda Moon**, manager of health promotion.

Moon says that a team of representatives from the company's different business units, facilities group, environmental safety and health, and benefits department is currently looking at several factors. These include the current location of designated smoking areas, maintenance costs incurred as a result of smoking, air condition and ventilation costs, and occupational illnesses and injuries related to secondhand smoke and productivity.

"We currently have an integrated data warehouse with all of our medical, pharmacy and disability data, so we can determine the impact of tobacco-related disorders on our overall claims experience, and the number of people who are using disability dollars as a result of smoking-related illness," Moon says. "We are pulling that data now, to begin to evaluate that."

Measuring loss of productivity due to smoking is more difficult. "That's a really hard thing to get your arms around," says Moon. The team is currently calculating the total time spent away from the work site due to smoking breaks that are being taken.

"Before we proceed, we will do some polls and studies with our management team to see how it may impact business operations if we do this," she says. "We want to be cautious about doing it in the right way if we move forward."

That includes giving employees ample warning at least a year to quit smoking before the workplace goes smoke-free, with a big push to boost participation in smoking cessation programs. "We don't see a real high utilization of our current smoking cessation program. We are looking at a more intense program, delivered in a different model, either phone or on site," says Moon.

Currently, an on-line smoking cessation program is available and prescription medications covered. The company is considering covering over-the-counter nicotine replacement therapy and offering flexibility in the workplace to make it easy for employees to attend programs onsite.

In 2008, employees who smoke pay $30 a month extra for medical premiums. The same charge applies for an adult dependent covered under the plan, so if an employee and their spouse both smoke, they pay up to $720 extra annually. The goal is to help employees kick the habit and be able to sustain that over the long term, says Moon.

"Some companies make a decision and implement this in 30 days, but we think it's critical to give a really long lead time," says Moon. "If employees are not successful on their first try, they will still have time to attempt it again and hopefully be

successful before the policy would go into place."

### Reference

1. Seo DC, Torabi MR. Reduced admissions for acute myocardial infarction associated with a public smoking ban: Matched controlled study. *Journal of Drug Education* 2007; 37(3):217-226. ■

# Adults need training in preventing child sex abuse

*Teach ways of avoiding risky situations and cases*

The number of child sexual abuse cases could be dramatically cut by educating adults on how to prevent it from happening, says **Nancy Chandler**, ACSW, executive director of the Georgia Center for Child Advocacy in Atlanta.

Also, child sexual abusers could be more swiftly identified if adults are educated on the potential symptoms and on how to recognize suspicious situations, she adds.

Adults need to be trained on how to protect children from sexual abuse, because many incidents could be avoided if awareness were increased.

Currently, one in four girls and one in six boys will be sexually assaulted before the age of 18, says Chandler.

"Childhood sexual abuse is not an isolated incident; it is rampant throughout our country and through society. We also know that less than 10% of children that are sexually abused ever tell anyone," she says.

According to national statistics 80,000 confirmed cases of child sexual abuse occur each year. "We know that is only 10% of the cases, so there were probably 800,000 children that were sexually abused last year," says Chandler.

There are many reasons children don't tell someone they are being sexually abused. One reason is *that* the person involved is trusted by the child someone in charge of him or her, such as a coach, teacher or relative. "There is a relationship issue, so it is really hard for kids to talk about it," explains Chandler.

To help change the statistics, the Georgia Center for Child Advocacy has in place the Stewards of Children Training, a two-and-a-half hour program for parents, educators, coaches, youth organizers, and other adults. It covers seven steps on protecting a child from sexual abuse and appropriately dealing with situations should they occur. There is also a train-the-trainer program that helps increase the amount of people qualified to provide education.

While this program is aimed at reaching people throughout Georgia, many states have similar programs, says Chandler. This program is also offered internationally through an organization based in Charleston, SC, called Darkness to Light.

What types of information needs to be covered in a good educational program on the prevention of childhood sexual abuse?

Chandler says that first, adults must have the facts. This helps to raise awareness. Many adults know that it happens but aren't really paying attention. Adults need to pay attention and notice what is going on around them, says Chandler.

The next lesson is to teach adults how to minimize opportunities for sexual abuse by reducing one-on-one adult and child interactions behind closed doors. Chandler says this, of course, does not refer to parents but to other individuals, such as coaches and teachers. For example, if a teacher is tutoring a child, the classroom door should be open.

When youth organizations, churches, and schools create policy and provide training, everyone knows the rules and is more likely to notice when someone is not following them, explains Chandler.

In addition, sexual abuse needs to be openly discussed, because it is so prevalent in society. Often people don't want to bring the topic up when meeting with baseball or soccer coaches and Sunday school teachers, because it sounds like they are suspect, but it must be discussed, says Chandler.

"We need to get the whole nature of childhood sexual abuse into the public forum of communication as with any of the other kinds of things in society that can harm us," says Chandler. Drinking and driving is one example, she says. As public awareness was raised it became less socially acceptable to drink and drive, and the designated driver program was embraced.

### Recognizing possible signs

Because sexual abuse cannot always be prevented, it is important for adults to learn how to recognize the signs. Unlike physical abuse, it is invisible to the eye, says Chandler.

One way to identify it is to look for a dramatic change in a child's behavior or take note of times

when a child does not want to be with another adult. For example, an active, friendly child might suddenly become withdrawn.

Adults should also act on their suspicions, says Chandler. For example, sometimes a wife may notice her husband coming out of their daughter's room at an inappropriate time. If this should happen, it needs to be addressed, not ignored, says Chandler.

Another strategy to make sure sexual abuse is swiftly identified if it should occur is to talk openly with children. "I use the bathing suit strategy. I tell the child 'If anyone ever touches you in a place covered by your bathing suit that makes you feel uncomfortable come tell me,' that is as simple as don't touch the hot stove or look both ways before crossing the street," says Chandler.

She adds that making the topic matter of fact from the time a child can communicate is a good strategy.

Another area of education that is important to cover when teaching on sexual abuse is information on what to do if it should occur.

Chandler says parents or guardians of children need to have a plan for dealing with a day their child tells them someone touched them inappropriately. If a child falls and needs stitches, the parent would know how to react but many do not know what to do when they learn their child has been sexually abused.

For example, if an incident happens it is not appropriate for the parent to do a full interview with the child, but a call to child protective services or the police department needs to be made, says Chandler. The action taken all depends on the information the child gives. Sometimes a trip to a physician is appropriate.

Parents must also learn in advance how to react to such information.

"A child's first disclosure may be very minimal, and there may be a whole lot more going on, so it is important not to minimize what the child is saying and also not to overreact," says Chandler.

If a child has been sexually abused, it is a good idea to take him or her to a professional counselor to determine what impact the incident had on them and address the issues accordingly. A child who has been fondled could be deeply traumatized if the offender was a favorite uncle or grandfather, says Chandler.

"If a child understands it is not their fault and he or she didn't do anything to bring it along, a long counseling session may not be necessary," says Chandler.

Parents and guardians must be very diligent in protecting their children. It is important to investigate day care centers thoroughly before enrolling a child and making sure that parents are welcome at all times. Also children should not participate in sports leagues unless coaches and trainers undergo background checks. All employees at schools and day care centers should undergo this same scrutiny.

"It is tough being a parent today, because there are so many demands on their time and their children's time, but they need to have some basics to begin with on how to keep their kids safe," says Chandler.



## COMING IN FUTURE MONTHS

- Case management for seniors with special needs
- Keeping members with heart failure out of the hospital
- Helping patients transition from hospital to home
- How to provide culturally appropriate case management

# CE questions

1. According to **Elizabeth Hogue**, Esq., every case manager should have his or her own private insurance.
   A. True
   B. False

2. Which occurred after a smoke-free workplace was implemented in Indiana's Monroe County?
   A. Hospital admissions for heart attacks decreased for nonsmokers.
   B. Heart attack risk decreased, but only for smokers.
   C. Secondhand smoke was found to be less hazardous for nonsmokers than expected.
   D. There was not much of an impact on the health of either smokers or nonsmokers.

3. To provide health care and education to the underserved, Mount Carmel partners with churches for the following reason/s?
   A. People feel safe and comfortable.
   B. It's a good place to teach self-responsibility for health management.
   C. Trained ministry team is available to aid in education.
   D. All of the above.

4. To reduce opportunities for childhood sexual abuse adults should learn which of the following?
   A. Be careful of one-on-one activities behind closed doors.
   B. Trust close friends and relatives completely.
   C. Don't rely on suspicions but wait for facts.
   D. Avoid open discussions of the topic.

**Answers: 1. A; 2. A; 3. D; 4. A.**



## CE objectives

After reading this issue, continuing education participants will be able to:

1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how those issues affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities. ■

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

A young man who participated in the Stewards of Children education program was showering at the YMCA after working out one morning when he heard a discussion in the next shower stall between a young boy and an older man that he felt was not appropriate. Therefore, he discussed it with the child's mother upon leaving the locker room. As a result a child molester was stopped.

"We all have to be very vigilant and pay attention to what is going on with the kids. That is the only way we can finally root this problem out," says Chandler. ■