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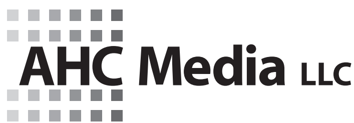
Covering Case Management Across The Entire Care Continuum



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Financial disclosure:
Editor **Mary Booth Thomas**, Associate Publisher **Coles McKagen**, Managing Editor **Jill Robbins**, and Nurse Planner **Betsy Pegelow** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

MAY 2008
VOL. 19, NO. 5 • (pages 49-60)

Software improves productivity, saves time for field-based case managers

Documentation, reports, letters completed in real-time

Not long ago, case managers for Medical Management International lugged huge cases of patient files with them when they visited clients and often worked into the night, entering documentation and patient notes into their computers.

Now, thanks to a productivity software system, the case managers need only a notebook computer and can enter their documentation, access patient files, and send out reports and letters while they are talking with their patients or waiting in an office.

"I know a lot of case managers who go around with a stack of files and a lockbox, and that is what our case managers had to do in the past. Now, we each have a 12-inch tablet PC with an air card," says **Suzanne Tambasco**, RN, BSN, Med, CCM, CBMS, CRRN, COHNS/CM, LNCC, NCLCP, CEO of the suburban Atlanta-based company and a practicing case manager.

Medical Management International (MMI) contracts with insurance companies to manage workers' compensation claims, legal liability, short-term and long-term disability, and legal nurse consulting

The case managers all work in the field, working out of their cars and often spending eight to nine hours a day on the road or seeing clients. Then they have to complete their documentation, send out reports and letters, and document their time for billing purposes.

Billing up to date now

In the past, the case managers often had a backlog of reports and documentation for billing purposes because of the manual operation. They didn't always document their time correctly because they simply couldn't remember everything they did once they started the documentation process.

Since the firm started using the software system, the case managers

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are able to handle 60% more business and the reports and billings are up to date, Tambasco says.

"Case managers in the field are paid on billable hours and we have to document it well in order to get paid. Health care is a business and you have to focus on getting paid as well as taking care of clients. Instead of jotting down notes and entering time for billing later, this system allows the case managers to document it in real-time," Tambasco points out.

The system has decreased the cost of office supplies — such as paper, ink, faxing, and storage — and increased productivity, allowing MMI to eliminate two part-time administrative positions.

Tambasco configured her own case management software system using document management software that was easy for her to customize to fit the needs of her company.

Taking control of work flow

The system includes a work flow process that guides the case managers from the time they open the first report on a patient through the entire management process until the case is complete.

When a case is open, the system generates a task list and sends regular reminders to the case managers of tasks waiting to be completed.

Tambasco and her case managers have created a cache of custom standardized letters that are automatically generated to update therapists, employers, attorneys, or insurance companies, including the data necessary for each recipient.

"A therapist needs to know the diagnostic information from the visit but the adjuster doesn't need that information. The attorney wants information on the objective issues. Everybody wants to know work status. The software generates the letters for each and adds the pertinent information," she says.

When MMI case managers are assigned a new case, they immediately contact the individual, physician, the employer, the therapist, and the attorney if one is involved.

"This could be the patient's first day in the hospital or a two-year old case," Tambasco says.

The case manager enters the name of the patient, a description of the injury, the name of the treating physician, and other pertinent information into the computer system. If the firm has worked with a physician, a therapist, or an attorney in the past, the case manager has to enter only the name and the rest of the data are automatically loaded into the patient file.

"Once the information is entered, it goes into the database and it never has to be entered again," she says.

If the company receives the patient's electronic medical record, it is automatically entered into the system.

When the case manager goes to the appointment module and enters an appointment with the physician, the software generates a confirmation letter to the patient.

When the patient completes an appointment, the case manager adds the outcomes information and notes and sends a report to the interested

Case Management Advisor™ (ISSN# 1053-5500), is published monthly by AHC Media LLC, 3525 Piedmont Road N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304 and at additional mailing offices. POSTMASTER: Send address changes to **Case Management Advisor**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $399. Add $17.95 for shipping & handling. Outside U.S.A., add $30 per year, total prepaid in U.S. funds. For approximately 15 CE nursing contact hours, $449. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $67 each. (GST registration number R128870672.)

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This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider # 14749, for 15 Contact Hours.

This activity has been approved by the Commission for Case Manager Certification for 18 clock hours.

This activity is valid 12 months from the date of publication.

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parties.

"Case managers don't treat patients. We communicate what is going on with the patient and if we don't do that quickly, there's no purpose for it. This allows us to get reports and letters out in a timely manner. We just fill out the screen with data and send it out. Instead of writing several individual letters, we can enter the data just one time and send it to whomever we choose," she says.

The system contains a prompting mechanism that alerts the case managers when they need to check on something.

For instance, if the case manager orders a wheelchair for the patient for an estimated 30 days, the case manager will prompt the patient to check to see if the wheelchair is still needed when the 30-day rental period is about to end.

"A lot of rentals are for 30 days and if you go over that you're stuck for another 30-days' rent. The system helps us remember so we don't waste the client's money," she says.

"The software sets a diary and an action plan for us. It automatically shows us all the documentation fields we need for our meetings, whether it's with a doctor or a therapist," she says.

The system allows the case managers to have the patient's entire medical record with them when they accompany the patient to appointments.

Tambasco tells of accompanying a patient to visit a physician who had not yet gotten the results of the patient's CT scan.

"I was able to go into my computer, download the report, and fax it to him on his office fax machine while I was still in his office with the patient," she says.

"This system allows us to input all our patient records, do a data search and get what we need. It's all on a secure server that meets HIPAA medical record keeping standards. We can multi-task and take care of sending letters and reports while we are waiting for the next appointment," she says.

The system allows case managers to share cases if they are busy or looking for a different perspective on a case. Each case manager's "diary," or to-do list, is on a "notice board and the schedules are available to all case managers.

"If I have appointments on opposite ends of town, I can have my colleague cover mine and me hers. If someone gets a call or has some free time, they can access my work and help me out or answer a question and bill for that.

"At the end of the day, [the system] gives us more time at home because we don't have to document or write reports in the evening and it makes our families happier, too," she says. ■

Reducing 'frequent fliers' in the emergency room

Medicaid members connect with primary care

By using a combination of education and case management, Molina Healthcare of Michigan has decreased the number of members who frequently visit the emergency department with primary care issues.

"We began this initiative after we determined that our emergency department rates were very high and that some of our members were going to the emergency department over and over for problems that could be handled in a primary care setting," says **Janet Marino**, RN, MSN, CCM, director of utilization management.

Molina Health Care of Michigan is part of a national managed care organization that provides coverage for Medicaid and Medicare members. In Michigan, the HMO has about 210,000 Medicaid members and about 1,300 Medicare members.

The health plan mines claims data each month and identifies frequent users for the emergency room case management program.

Anyone who has visited the emergency department three or more times in a month receives an educational package.

Educating patients

The packet includes information explaining Molina's health care benefits, including the name of the member's primary care provider; a list of urgent care providers; a phone number patients can call to access behavioral medicine services; and the health plan's nurse advice line number.

The letter emphasizes the importance of seeing a primary care physician, reminds the member that Molina provides transportation to doctors' appointments, and includes the transportation number.

Many times, the emergency department visits are the result of the member not understanding the health plan and its benefits, Marino points

out.

When members join the program, they have an opportunity to choose a primary care provider. If they don't choose, the plan assigns one to them.

Some of the members in the program don't know how to access their primary care provider and don't know that the health plan will provide transportation for primary care visits. Many of the members in the program have multiple comorbidities. About 18% of the population is disabled.

About two-thirds of members who receive the educational packet curtail their emergency room visits, while about one-third continue to use the emergency room frequently and are referred for case management. The case managers are assigned to a population of members based upon the members' geographic location and provider group.

Members who are referred to case management receive a letter that identifies the nurse case manager who will be working with them and explains case management services.

Using a comprehensive assessment tool, the case managers contact the members and complete an extensive assessment that includes their medical history; home situation and support system; understanding of their disease and medications, including adherence issues; and barriers to getting care.

"The assessment tool helps the nurse determine why the member isn't receiving care in the office setting and how the case manager can help the member learn to manage their care and avoid the emergency department," Marino says.

The case managers put together a care plan based on the members' needs and follow up by telephone on a regular basis.

They work as a team with the health plan's social workers to facilitate behavioral medicine coordination and help with community resources.

"The population we serve frequently needs assistance with social issues as well as medical issues. They may be homeless, without heat, or have other needs," she says.

In the beginning, the case manager may call the member as frequently as twice a week, and then taper off to a few times a month, depending on the member. When the member's emergency room utilization tapers off, the barriers to primary care have been resolved, and the member is able to manage his or her condition, the case manager will close the case.

When the case managers contact the members, they facilitate scheduling needed appointments while they still have the member on the telephone.

"Sometimes the nurse will make a three-way call while the member is on the line and get them into services right away. It's always helpful if we can set appointments when the member is on the line," she says.

If the case manager has any concern about the member's physical condition, home situation, or immediate medical needs, the health plan will send out a home care nurse to evaluate the situation and contact the member's primary care physician if appropriate.

The home care nurse conducts an assessment, evaluates the member's medication adherence, and home situation, and works with the case manager to determine if more support is needed.

One of the plan's medical directors, **David Donigian,** MD, a board-certified emergency medicine physician, works closely with the case managers on the program. The team conducts case rounds monthly to evaluate the progress of each member.

Many of the members who are using the emergency department have chronic pain. The case managers will help them access a pain management specialist or a pain clinic to help get their pain under control. If the members appear to have substance abuse problems, they are referred to behavioral health.

In the rare case of patients who clearly are drug seeking, the case manager works with Donigan, the plan's pharmacy department, and the primary care physician, as only one treating physician can write the member's prescriptions for pain medicine. The pharmacy won't fill the prescription unless it's signed by that particular physician.

"We try to coordinate with a pain management specialist who can work with the member on pain management. Some members don't know what to do and go to the emergency room to get some relief," she says.

If members quality for one of Molina's specialty case management programs or disease management programs, the case managers refer them to the appropriate program.

Molina's specialized case management programs include: congestive heart failure, chronic obstructive pulmonary disease, cardiovascular disease, end-stage renal disease, oncology, organ transplants, high-risk obstetrical, and pediatrics. ■

Nurse practitioner model improves care for elderly

Proactive approach keeps patients out of the hospital

A nurse practitioner-led care management model has resulted in lower costs, better care, and high patient satisfaction ratings for frail elderly nursing home patients being managed by Inspiris, a Brentwood, TN-based health care management firm.

Inspiris and Mercy Care Plan of Arizona nurse practitioner care management model was named the best practices award winner in URAC's first Best Practices Consumer Empowerment and Protection Awards program in March.

Medicare managed care plans contract with Inspiris to manage the care of their members in nursing homes. The nurse practitioners visit the patient in person in the nursing home and collaborate with the nursing home staff, the attending physician, and the family.

Patients in the program typically have 300 to 350 hospital admissions per 1,000 compared to a typical Medicare rate of 1,200 to 1,400 admissions per 1,000, says **Sarah White**, NP, vice president of clinical operations for Inspiris.

In a recent study of the New York market, an analysis of Medicare claims data indicated that the Inspiris CarePlus plan reduced emergency room use by 46% and hospitalizations by 74%.

In Phoenix, one health plan that contracted for the program assigned half of its members and facilities to the Inspiris nurse practitioner care management model and half to the physician-only model.

Over the first eight months of the Phoenix pilot study, acute inpatient hospital admissions for the patients whose care was managed by a nurse practitioner dropped 63% per 1,000 as compared to the control group, White reports. The results were so compelling that the pilot study was dropped and all the patients in the plan were enrolled in the Inspiris program, she adds.

One-on-one care

The program is different from traditional case management and disease management models because the nurse practitioners see their patients in person, rather than relying on telephone calls to manage care.

"Telephonic care management doesn't work with patients who are cognitively or functionally impaired or those in a nursing home. Our model represents a major shift in the way health care is being delivered in the long-term care setting," she adds.

The frail elderly population is among the biggest drivers in health care costs, particularly during the last 18 months of their lives, White points out.

"Most health care is delivered in the nursing home through a physician-reactive model. Under fee-for-service Medicare, physicians see the patients only if it's a visit required by Medicare regulations or if it is deemed medically necessary. We see the patients frequently and pick up problems early, revise treatment plans, and deliver care in a timely manner," she says.

The nurse practitioner serves as a case manager and the primary care provider, working with the physician and the nursing home staff.

"The nurse practitioner sees the patients an average of once a week, sometimes with the physician and sometimes alone," White says.

Even subtle changes, such as not eating or sleeping well, can be a sign of failing health in an elderly person, White points out.

"The physicians visit so infrequently that the nurses may forget to tell them about problems. But when the nurse practitioners visit, they specifically ask the nurses about subtle changes and can take proactive steps," she says.

The nurse practitioners usually cover two to three nursing homes, depending on the volume of patients. Their typical caseload is between 80 and 100 patients. They spend their time at the nursing home or in transit and document their findings on a laptop computer.

Patients are enrolled in the Inspiris program through their health plan contract with Inspiris.

Practitioners use an assessment tool that helps them stratify the patients as high, medium, or low risk, based on factors that include the severity of their chronic medical conditions and past medical utilization. The tool includes a cognitive function assessment, fall risk assessment, depression screening, and skin assessment. The nurse practitioner also performs a comprehensive history and physical examination.

The nurse practitioner uses all of the information from the assessment tool and his or her clinical judgment to set the risk level of each patient.

"The nurse practitioner is seeing the patient in person and may pick up something that the tool

didn't. The tool is a good indicator of risk but it doesn't replace the nurse practitioner's professional judgment," White says.

The nurse practitioners meet the family member who is the legal representative for the patient, review the medical record, and talk to the family member about the patient. They talk to the family frequently, sometimes over the telephone and sometimes in person.

"During the introductory visit, the nurse practitioner begins to establish a relationship with the family. A lot of our work involves communication, and when patients can't make decisions for themselves, it's essential to have a good relationship with the family," she says.

The nurse practitioners educate the family members on medical issues, where the loved one is in their disease process, and what their prognosis is.

"We try to give them the big picture and educate them about the trajectories that are part of the aging and disease process," she says.

They work with the family on end-of-life planning and help them make decisions about hospice or palliative care as the patient's condition worsens.

The nurse practitioners visit their patients on a regular basis and work on preventive measures, such as immunization, fall prevention, and pressure ulcer prevention. They work with the nursing home staff to manage multiple chronic and acute conditions.

The company has developed protocols for managing the care of elderly patients with chronic diseases.

"The goal is to be proactive and to create a treatment plan that is appropriate for each patient. We talk to the family and patient to get their input about treatment decisions. We might not treat conditions in this age group as aggressively as we would in a younger population," she says.

With an older patient, palliative care to keep him or her comfortable may be more appropriate than aggressively treating a disease to prevent negative outcomes, White says.

"We examine each treatment decision independently and work with the patient or surrogate to make informed decisions that guide the rest of the protocol," she says.

"The nurse practitioners are in the facility frequently and get to know the staff who are providing care for the patient. They work with a multidisciplinary team that may include nurses, dieticians, social workers, and a consulting pharmacist," she says.

Since they are in the facility regularly, the nurse practitioners can pick up on subtle changes in a patient's condition early on. Often, the facility staff mention a change to them.

"The facility nurses develop a relationship with the nurse practitioner and will mention that Mr. Smith isn't eating or sleeping well. This is a red flag to the nurse practitioner to begin an in-depth assessment and manage the problem safely in the nursing facility if possible," she says.

The process pays off, even during flu season when the hospitals are often packed with patients, White says.

This year's flu season was particularly rough and one nurse practitioner with 50 patients in one facility saw many who developed the flu or other respiratory symptoms but only one was admitted to the hospital.

"She managed the rest successfully in the nursing home. She was able to identify the problems early and take steps before the patients got so sick they had to be hospitalized," she says.

If a patient has to go to the hospital, the nurse practitioner calls the hospital or the emergency department and gives them a quick patient history.

"The nurse practitioner reminds the hospital staff that the patient is in a nursing facility that can handle many things like IV antibiotics, therapy, or wound care. This awareness results in a shorter hospital stay," she says.

"We give the family an update at least quarterly and more frequently if there is a change in the patient's condition," she says.

The nurse practitioners follow the patients through the continuum of care, from the nursing home to the hospital and back again.

"Over time, the nurse practitioner gets to know the patient and family really well and a trusting relationship develops," she says.

The nurse practitioners establish a good working relationship with the health plan case managers so they can collaborate if issues arise.

For instance, in the case of high-risk, complex patients, since the nurse practitioners see the patients in person, they can give the health plan case managers additional information to take to the plan's medical director when issues of coverage arise.

If a patient is discharged from the nursing home to the community or to a group home or assisted living center, the nurse practitioner coordinates the transfer with the health plan case manager. ■

Should employees be given cash to lose weight?

Investment pays off — at least for the short term

Many employers give premium reductions to workers who complete health risk assessments or attend weight loss programs, and some firms are considering charging obese workers more for health benefits. But what about giving workers cash as a reward for losing pounds?

A study of 200 overweight employees at three North Carolina colleges suggests that even a small amount of money can result in significant weight loss.[1]

During a three-month period, one group received no incentives, and the other two groups received $7 or $14 for each percentage point of weight they lost. For instance, a 200-pound employee in the $7 group who lost 10 pounds would get $35. Workers got no help for how to lose weight. The unpaid employees lost an average of two pounds each, but those in the $7 group lost an average of three pounds each, and those in the $14 group lost an average of 4.7 pounds each.

"What we learned is encouraging," says **Laura Linnan**, ScD, one of the study's authors and an associate professor at the University of North Carolina at Chapel Hill's School of Public Health. "You probably can't solve the whole obesity problem with this approach. We need to understand more about it before we start restructuring benefits. But cash incentives do seem to provide some motivation."

This approach is appealing to many employers because few resources are required to implement it, says **Eric A. Finkelstein**, PhD, director of the public health economics program at RTI International, a research institute based in Research Triangle Park, NC. As opposed to building a fitness center or implementing a wellness program, the program doesn't have any costs unless employees lose weight, he explains. "If they do, then you only pay them what you agreed to upfront," he says. "There is evidence that these programs are on the rise."

The dollar amount to offer employees remains an open question. "Until there is better evidence on return on investment, it's hard to say what the right level is," says Finkelstein. A "good target" is $500 for the total incentive employees can earn in a year for losing weight, he suggests. Even though many employers give incentives for completing a health risk assessment or attending coaching sessions for weight management, participation often remains low, says **LuAnn Heinen**, director of the National Business Group on Health, which studies the costs and effects of obesity. "Health and healthy weight should, over time, be its own reward," says Heinen. "However, incentives do get employee attention and can move people from 'I'm going to work on this at some point' to 'I'm starting now.'"

If considering implementing financial rewards for weight loss, consider the following items:

• **Use incentives to maintain weight loss.**

At O'Fallon, MO-based VSM Abrasives, employees received either $125 or a day off for every 10 pounds they lost from July through December 2007 as part of the company's Get Healthy for Life program, reports **Denise Drew-Douglass**, HR manager. A total of $1,250 was paid out to six employees; three lost 10 pounds, two lost 20 pounds, and one lost 30 pounds. To ensure that results aren't just short term, employees must keep it off for one year, or they have to pay the money back, says Drew-Douglass. Employees go into "maintenance mode" by participating in a monthly weigh-in, with the president of the company handing out $25 or a certificate for a day off, whichever the employee chooses, to individuals who meet target BMI ranges or lose 10% of their initial weight and stay at that number.

About 80% of the company's 125 employees participate in the maintenance program. "If you are in a healthy BMI, you receive $25 every three months and a day off on the 12th consecutive month," says Drew-Douglass. "So you can receive $100 per year plus a day off with pay. About 50% of our employees receive these incentives regularly."

Several people have made positive changes regarding their weight and kept it off for a long time, she says "The benefits are hard to put in dollar amounts. We have great morale, low turnover, and very happy employees," Drew-Douglass says. She estimates that the company has paid out $23,000 for the maintenance program over the past four years.

• **Don't leave out employees who don't need to lose weight.**

Employees should be rewarded for taking action to improve or maintain good health, regardless of their weight, says Finkelstein.

"Weight is an easily measurable metric, but of course genetics plays a role in weight," he adds. "One might consider other clearly measurable targets, such as completing a running or bike race, as an indicator that the individual is clearly making efforts to improve their health."

• **Offer other rewards**.

In Arkansas, state employees get up to three days off per year by earning points for quitting smoking, eating more fruits and vegetables, and increasing physical activities.

"How quickly an employee can earn a day off is different for each person, depending on how aggressively or slowly they do the activities," says spokeswoman **Helen Weir**. A total of 4,750 points must be earned for a day off, and employees earn one point for each serving of fruit or vegetables eaten, one point for every 10 minutes of cardiovascular exercise, 100 points for completing a health risk assessment, and five points for each day tobacco is not used. More than 2,500 workers have registered, and 947 have earned time off work.

At Freedom One Financial Group in Clarkson, MI, an annual contest awards a grand prize each year to employees who lose the most body fat. "Last year we broke into teams of four. The team who lost the most body fat won a free cruise," says **John Young**, vice president of retirement plan sales. Fifty of the company's 65 employees participated, with an average weight loss of 6.5 pounds and body fat loss of 1.41%, Young said. The cruise for four employees cost about $5,000, he says.

Paying employees outright for weight loss might be somewhat "short sighted," says Young. "The goal is to create healthier employees through healthier lifestyles, not just skinnier employees. We don't want to encourage people to lose weight for the wrong reason," he says. "Fat content as the measurement for the payment might be a better way to incent the employee."

More than 85% of Blue Cross and Blue Shield of North Carolina employees complete a health screening and risk assessment to receive up to a $600 deduction on health insurance premiums. "We also do an annual physical activity and nutrition challenge, called Blue Challenge," says **Sarah Weiser**, PhD, the company's director of employer health partnerships.

Based on their personal health goals, employees participate in categories of losing weight, reducing body fat, or maintaining their weight, she says. "There were 173 participants, and they lost a combined 634 pounds," says Weiser. Prizes for winners in each of the categories included a $100 gift card, a $50 gift card, and a $25 gift card.

• **Evaluate long-term outcomes.**

"This type of incentive only addresses initial weight loss which, according to most experts, is the 'easy' part," says Heinen. "The real challenge is weight maintenance." Even if some or all of the weight is regained, however, annual campaigns can help prevent the two to four pound per year weight gain that is typical for adults, she says.

• **Don't eliminate other programs**.

Paying employees to lose weight should not substitute a comprehensive wellness program, including healthy lifestyle education, healthy dining initiatives, support for physical activity at work, on-line or onsite weight management programs, coverage of nutritional counseling, or other coaching services, says Heinen.

The bottom line? "If a company has extra dollars to invest, and paying employees to lose weight is a fit in terms of company culture, then it can be a fun and attention-getting option," Heinen says.

Reference

1. Finkelstein EA, Linnan LA, Tate DF. A pilot study testing the effect of different levels of financial incentives on weight loss among overweight employees. *J Occ Environ Med* 2007; 49:981-989. ■

Flexible workplaces are healthier for employees

Let employees structure their own schedules

Employees who perceived greater flexibility in their workplace were more likely to engage in more frequent physical activity, stress management programs, health education activities, and healthful sleep habits, according to a new study.[1]

Data come from health risk appraisals completed by 3,193 employees of GlaxoSmithKline, including executives, administrative support staff, and warehouse and production workers.

"This study reinforces the idea that workplace flexibility is important for health," says **Joseph G. Grzywacz**, PhD, the study's author and associate professor in the Department of Family and Community Medicine at Wake Forest University

School of Medicine in Winston-Salem, NC. "Individuals who perceive an increase in their flexibility are more likely to start some positive lifestyle behaviors."

Why are flexible work environments healthier for employees? One possible reason is that workers simply lack the time to engage in healthy lifestyle habits, says Grzywacz.

If employees are able to structure their own schedules, this allows them to free up bigger blocks of time, says Grzywacz. "If they can find an open hour at some point, they may be more likely to exercise than if they have no control over their schedule whatsoever," he says. "They can use their time more effectively, so they don't have a bunch of 15-minute blocks of time that they can't do anything with."

Having more flexibility may simply make life easier, leading to less stress and better sleep, adds Grzywacz. "I think there is something to be said for giving people some mastery over their own schedule, to live the typical lifestyle that the occupational health professional wants them to have," he says.

To promote a sense of flexibility, some employers offer compressed work weeks, flex time schedules, or allow employees to work remotely. "But it's not so much what organizations do — it's how well they implement it," says Grzywacz. "If you put a program on the books, but the manager is still watching the clock, that is not going to be effective."

More flexibility also increases productivity, since employees are more willing to put in extra time when asked, he says. "So it doesn't really matter what they use the flexibility for — the organization will still get something out of it," says Grzywacz. "It's good for the organization on multiple fronts."

Informal programs more common

GlaxoSmithKline's employees are provided with benefits coverage and a healthy, flexible work environment, but it is up to the employee to take responsibility for making lifestyle changes, says **Ann Kuhnen**, MD, MPH, vice president of employee health management.

"Perceived flexibility enables people to engage if they want to," she says. "People who want to make changes but don't have the perceived flexibility are less likely to make changes. So we need both the flexibility and the personal motivation."

The long-term goal is for employees to contribute to the workplace over time by preventing burnout, says Kuhnen. "People prioritize themselves as third after work and family," she says. "In other words, if forced to prioritize, people tend to let their own health needs slide."

GlaxoSmithKline is committed to fighting the epidemic of chronic diseases, which is the primary driver of health care costs in the United States, through prevention programs, proper disease management, and continued medical research, says Kuhnen. "However, the competing pressures of work and family often make it a challenge for many employees to take care of themselves," says Kuhnen. "With a flexible work environment, some of this pressure is alleviated, so employees can find ways to incorporate their personal needs, such as exercise or medical checkups, while still meeting their work obligations."

At GlaxoSmithKline, employees are offered formal flexible work options, such as compressed work weeks or part-time hours, and informal flexibility. "We don't know the breakdown of people who had formal vs. informal flexibility in this study," says Kuhnen. "But we know from our own data that the vast majority of people have access to informal flexibility, while only 10-15% of our workforce has taken advantage of a formal flexible work schedule."

Informal programs are arranged on an ad hoc basis with managers and teams, and they range from leaving early for dental appointments to working from home for a period of time should the need arise, says Kuhnen. "For employees with responsibilities that allow them to work remotely, we can focus on making sure the work gets done on time, not necessarily whether they did it at their desk," she says. "For others, it can be as simple as shifting the work day from 9 a.m. to 5 p.m. to 7 a.m. to 3 p.m."

It is hard to predict what types of lifestyle changes people are most likely to make with more flexibility in their schedules, says Kuhnen. "This study showed that people who reported an increase in their perceived flexibility from one year to the next reported longer sleep and participation in health promotion programs," she says.

Reference

1. Grzywacz JG, Casey PR, Jones FA. The effects of workplace flexibility on health behaviors: A cross-sectional and longitudinal analysis. *J Occ Environ Med* 2007; 49:1,302-1,309. ■

Obese more likely to return after surgery

Medically disabled Medicaid patients who are obese and have bariatric surgery are more likely to return to work than those who don't have surgery, according to a new study.[1]

Obesity is linked to diabetes, hypertension, hyperlipidemia, degenerative arthritis, sleep apnea, and left ventricular hypertrophy, and results in dramatic increases in health care costs, says **Richard Thirlby**, MD, the study's lead author and a bariatric surgeon at Virginia Mason Medical Center in Seattle.

Researchers studied 38 medically disabled patients receiving Medicaid who had Roux-en-Y gastric bypass performed by a single surgeon between 1997 and 2002. They compared these patients with 16 patients receiving Medicaid who were seen by the same surgeon, but did not undergo surgery.

Employees who had the surgery were more likely to return to work, with 37% working, compared with 6% of the other group. "Our study makes a convincing argument for the role of weight loss surgery in morbidly obese Medicaid patients," says Thirlby.

Return to work was more likely in patients who had resolution of comorbid conditions after surgery, such as sleep apnea, diabetes, hypertension, and severe degenerative joint disease, says Thirlby. "On the other hand, return to work was less likely if the patients had no comorbidities or had too many — the cow is out of the barn' population," he says.

These findings suggest that reversible obesity-related comorbidities may be an appropriate prerequisite for approval of bariatric surgery, says Thirlby.

Productivity increased

"Our study involves a trivial number of employees, compared to the entire American work force," says Thirlby. "What about the millions of morbidly obese people in this country who are working despite their disease?"

There is no question that an employee who undergoes successful weight loss surgery will be more productive at work within six to 12 months, with fewer sick days, he says. "They will be more functional, mobile, and alert," says Thirlby. "I could give you countless examples of patients who report that their careers improved after weight loss surgery."

Obesity surgery provides "quality-adjusted life years" that are well within accepted ranges related to "cost-effective" interventions, notes Thirlby. "The problem as I see it, however, is that it takes about six to 12 months to realize the benefits of increased productivity," he says.

The actual cost of the surgery is at least $20,000, and indirect costs include two to six weeks off work post-surgery, says Thirlby. "It takes up to three years to recoup these expenses with decreased health care costs," he adds. "Given the portability of employees, I suspect that most employers would not be willing to allow two to three years to 'get their money back.'"

It's a "no brainer" that bariatric surgery, when performed with appropriate indications and at medical centers of excellence, will increase the employee's health and productivity, says Thirlby. "However, the present data do not allow us to determine definitively the dollar investment required to achieve this benefit," he says.

Reference

1. Wagner AJ, Fabry JM, Thirlby RC. Return to work after gastric bypass in Medicaid-funded morbidly obese patients. *Arch Surg* 2007;142:935-940. ■

Findings of Kaiser report reveal progress, pitfalls

Major findings of a recent report by the Kaiser Commission on Medicaid and the Uninsured include the following:

1. Some 32 states, including Washington, DC, took actions to increase access to health coverage for low-income children, pregnant women, and parents. Of the 32, 26 states authorized or adopted income eligibility expansions, 11 states reduced procedural barriers, and seven states reduced financial barriers to Medicaid and SCHIP. While most activity was focused on children, there also were modest improvements for pregnant women and parents.

2. Some 26 states improved access to children's health coverage. Of the 26 states, 12 raised or authorized raising SCHIP income limits to 300% of the poverty line or higher, more than doubling the

number of states setting eligibility at that level. Plus, nine states simplified enrollment procedures and seven states reduced coverage financial barriers.

3. Some 14 states enacted moderate children's coverage expansions focused on particularly vulnerable populations such as infants or children discharged from foster care at age 18. The changes included modest income eligibility expansions, increasing the SCHIP asset limit, and allowing children who are discharged from foster care at age 18 to retain Medicaid through age 21.

4. No state cut back income eligibility for children, but a few states restricted eligibility. Thus, three states froze children's enrollment and two states imposed or lengthened waiting periods. The analysts say experience from states that have had enrollment freezes indicates that most children who are closed out of coverage have no alternatives and remain uninsured, missing out on needed health care including prompt medical treatment, medication, preventive exams, and immunizations.

5. States claim progress in adopting simplified enrollment and renewal procedures in children's Medicaid and SCHIP, particularly emphasizing strategies reducing paperwork and jump-starting enrollment. Nine states took steps to simplify enrollment and renewal procedures for children Several basic simplified strategies such as disregarding assets in determining eligibility, allowing enrollment and renewal without an in-person interview, and limiting renewal frequency to once a year, have been adopted for children almost universally. Only Georgia retracted a simplified procedure in its children's health coverage program during the survey period.

6. The Medicaid citizenship documentation requirement continues to impede state simplification efforts by complicating enrollment, especially for children.

7. Seven states reduced or eliminated premiums for children's health coverage, but another seven states either imposed new premiums or increased the amount of existing premiums.

8. Twelve states and the District of Columbia enacted modest coverage expansions for pregnant women and parents and no state retracted eligibility for these adults. Nine states increased eligibility for pregnant women, either by expanding income eligibility or by adopting the option to cover unborn children in SCHIP. Six states took steps to expand health coverage for parents.

9. Income eligibility for parents still lags behind eligibility for children, although the disparity was reduced a bit in 2007.

10. Efforts to simplify enrollment and renewal procedures for parents continued, but the report says it remains harder for an eligible parent than for an eligible child to obtain and keep coverage. Research indicates that efforts to cover low-income parents in programs like Medicaid and SCHIP increase the enrollment of eligible children. Also, when their parents are insured, children gain better access to health care and improve use of preventive health services. The analysts say efforts to expand parent coverage will help advance enrollment of children as well, while limits on parent coverage could pose a barrier to enrolling more children. ■

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COMING IN FUTURE MONTHS

- Collaborating to manage the care of catastrophically injured patients
- How telemedicine helps case managers coordinate care
- Partnering with other disciplines to keep patients from falling through the cracks
- Bringing disease management into the workplace

CE questions

17. Since Medical Management International started using its new software system, it has been able to handle 40% more business.
    A. True
    B. False

18. Janet Marino's specialized case management programs include which of the following:
    A. congestive heart failure
    B. cardiovascular disease
    C. organ transplants
    D. all of the above

19. Which is true regarding financial incentives given to employees to encourage weight loss?
    A. Payment is effective for short-term weight loss.
    B. Long-term weight loss was significant.
    C. Financial incentives should replace other wellness programs.
    D. Incentives are not effective for short-term weight loss.

20. Which is true regarding workplace flexibility?
    A. Employees with flexible work schedules were more likely to be obese.
    B. Informal flexibility programs are linked to poor eating habits.
    C. Only formal flexibility programs had a positive impact on wellness.
    D. Employees with more flexible work schedules may be more likely to engage in healthy habits.

Answers: 17. B; 18. D; 19. A; 20. D.

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

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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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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. ■