# CASE IN POINT

## Leading the Care Coordination Team with Knowledge, News and Learning

## DEPARTMENTS:

*"In the flurry of activity to advocate, communicate, educate and navigate as a member of our client's care management team, we may be losing sight of our own health and well-being and its impact on our clients."*

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## FEATURES:

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# Injecting a Dose of *Health* Into Healthcare

Welcome to the August 2013 issue of *Case In Point*. In this issue we turn a keen eye to a hugely important element of today's healthcare system: the topic of health and wellness.

Today, educating and empowering clients to recognize the impact that their behaviors have on their health and wellness is key to moving to a true *health*care system. Yet doing so means that it is incumbent on each member of the team to learn the best strategies that will enable them to listen to the patient, find out their goals, and understand the motivating factors that they use to improve not only their health but their very quality of life.

In this issue of *Case In Point*, we feature an array of professionals who share their intuitions and practices that are achieving great success in educating and empowering the consumer. Also among these in-depth articles is a glimpse at what healthcare professionals are doing to improve their own health and wellness, and I thank them for sharing their journeys.

Today, case managers and other members of the care coordination team are in an ideal position to assist consumers in recognizing their goals and help them work toward a healthier behavior regardless of age, not only because it will improve their health, but because it will help them meet their goals as well. Tools like motivational interviewing and healthcare coaching are changing the way we practice and are helping the team place a greater emphasis on the person's sense of self.

Healthcare is in the midst of sweeping change, as the industry recognizes that in order to control costs we need to focus on prevention. In this issue we present a collection of examples showcasing how this theory is being put into practice. I hope you take time to read each article and glean ideas that you can use in your personal life as well as with the patients you are called on to assist. For health professionals seeking fresh ideas, this issue is packed with information that is pertinent to your practice.

Once you are finished the issue, don't forget to access the learning portal and complete the posttest and program evaluation and claim the four containing education credits that are pre-approved for this issue. If you need assistance, feel free to email our client services department: clientservices@accessintel.com.

I am currently working on the 2014 editorial calendar, so please send me topics that you would like to see covered next year. Knowing your educational needs helps us ensure that *Case In Point* continues to stay on top of the trends impacting your practice.

*Anne Llewellyn*

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# HEALTHCARE BRIEFS

## CLINICAL

### Technology Blunders to Blame for 1 in 4 Operating Room Errors

A large-scale review of operating room procedures found that technology- and equipment-based problems are behind approximately one-quarter of total operating room medical errors, according to a new study published in *BMJ Quality and Safety*. Researchers also found, however, that the use of operating room checklists before surgery can trim the chance of a technology-based error in half. To reach their conclusions, researchers from Imperial College London analyzed 28 published studies on operating room errors and related malpractice claims. Eight of the studies pinpointed the various types of technology or equipment errors. The most common problem had to do with the configuration or settings of an operating device, which caused an issue in approximately 43 percent of cases. This was followed by device availability, which affected 37 percent of cases, and the situation of a device or machine not working, which happened about one-third of the time. Four studies tracked the severity of errors, and researchers found that equipment failure was the cause of 20 percent of those with "major" problems. "The increasing use of technology in all surgical specialties may also increase the complexity of the surgical process, and may represent an increasing propensity to error from equipment failure," said the authors. CIP

## ACUTE CARE

### 6 Steps to Keep Heart Failure Patients Out of the Hospital (Again)

Of the more than 1 million individuals hospitalized due to heart failure every year, about one-quarter end up back in the hospital within 30 days of discharge. With readmission penalties hampering hospitals' reimbursement rates, the ability to keep patients healthy and out of the hospital has increasingly become a strategic quality initiative. A new research study from Yale University helps acute care facilities achieve those goals. Analyzing the quality data of more than 600 U.S. hospitals, researchers pinpointed six steps as the most effective ways to reducing readmissions for heart failure patients. They include: forming partnerships with community doctors; collaborating with other hospitals to engineer consistent strategies; empowering nurses to supervise medication plans; scheduling follow-up appointments with post-acute providers before the patient is discharged; using systems to forward discharge information to primary care doctors; and contacting patients about test results after they leave the hospital. According to Elizabeth Bradley, professor of public health at Yale, reducing heart failure-related readmissions by just 2 percent would result in total cost savings of more than $100 million a year. The research appeared in *Circulation: Cardiovascular Quality and Outcomes*. CIP

## LONG-TERM CARE

### Incentives to Residents Spur End-of-Life Discussions

While many elderly patients hold deep-seated wishes for their final days – to die at home instead of the hospital, for instance – research shows that few individuals talk to their doctors and record their wishes. A new study from the University of California, San Francisco found that offering financial incentives to medical residents to engage patients in these discussions resulted in a significant increase in the number of seniors who not only took part in end-of-life conversations but who had their wishes recorded in their medical records. For the study, internal medicine residents each received a bonus of $400 if they discussed end-of-life wishes and appointed a decision-maker in the case of infirmity, among at least 75 percent of the inpatients they treated. Researchers tracked the medical records of nearly 1,500 patients, both before and after the program took effect. They discovered that, in short, the program was a tremendous success in documenting end-of-life decisions. Before the program began, just 22 percent of patients had documented end-of-life wishes in their medical records. Once the program was underway that number jumped to more than 90 percent. The study appeared in *JAMA Internal Medicine*. CIP

## HEALTHCARE DELIVERY

### Electronic Health Records Proliferate, Enhance Patient-Centered Care Delivery

A new set of federal data shows that more providers are using electronic health records (EHRs) than ever before, while these electronic-based systems are coaxing subtle transformations in the method of care delivery. According to recently published data from the Centers for Medicare and Medicaid Services (CMS), approximately 80 percent of eligible hospitals have adopted EHRs and received incentive payments from CMS; and more than 50 percent of professionals, mainly primary care providers, have likewise adopted EHRs. "More patient than ever before are seeing the benefits of their providers using electronic health records to help better coordinate and manage their care," said Dr. Farzad Mostashari, national coordinator for health information technology. Since the federal incentive program began in 2011: doctors and other providers have sent more than 190 million electronic prescriptions; health professionals have delivered 4.6 million electronic records to patients; patients have received more than 13 million reminders for appointments, tests and check-ups; and health providers have shared more than 4.3 million care summaries with other providers as patients transition from one setting to the next. CIP

## MANAGED CARE

### Small Employers Are Dropping Health Coverage, Says WellPoint

As health reform ramps up in advance of the implementation of key provisions in 2014, including health insurance exchanges and the "employer mandate," some small employers are dropping coverage in the face of uncertainty, according to WellPoint, the nation's second largest health insurance company. In a late-July call with shareholders, officials from WellPoint acknowledged that it expects to lose members among individuals sponsored by small employers. "We continue to see small group attrition accelerate even more as we get to the back half of the second quarter," said Wayne DeVeydt, WellPoint's chief financial officer, in a conference call. However, WellPoint expects to see a greater increase in membership among self-insured employer plans as well as individual plans that will be sold in the forthcoming exchanges. These trends follow a general pattern in the health insurance industry, as employers and other insurance purchasers face ambiguity surrounding the specific implementation policies of certain reform efforts. "What we are seeing is that more of the small group employers today still can't make a decision on choices yet because those choices are not readily available in the market until the exchanges are fully up and running," added DeVeydt. CIP

# Numerical Analysis of
# Health and Wellness

*In this edition of By the Numbers we explore the data and statistics behind the state of American health and wellness, with a specific focus on workplace wellness and the impact of work-based solutions.*

## 92%
More than nine out of 10 employers with 200 or more employees offer a workplace wellness program, according to 2009 data.

## 74%
Regardless of company size, approximately three-quarters of employers that offered health insurance benefits offered at least one wellness program.

## 3
The top three behaviors targeted in workplace wellness programs include: exercise (63 percent), smoking (60 percent) and weight loss (53 percent).

## <20%
While comprehensive data about overall participation in workplace wellness programs is elusive, one study from 2010 estimates that fewer than 20 percent of employees ultimately participate.

## $100-$500
Many employers have begun to use financial incentives as a way to promote employee health and wellness. Research shows that the average annual value of incentives per employee ranges between $100 and $500.

## 4
According to the Centers for Disease Control and Prevention, Americans are in the midst of a "lifestyle disease" epidemic, with four primary behaviors standing as the root cause of chronic disease – inactivity, poor nutrition, tobacco use and frequent alcohol consumption.

## 75%
Estimates show that chronic disease accounts for approximately three-quarters of all national health expenditures.

## 4x
Individuals with chronic disease incur four times higher indirect costs based on lost productivity and work absence compared to healthy individuals.

## 3:1
With more employers implementing workplace wellness programs, they are seeing a significant return on investment (ROI). A recent analysis shows that wellness programs realize an ROI of about three to one for both direct medical costs and productivity.

## 44%
Despite the evidence of effectiveness, just 44 percent of employers that offer workplace wellness programs believe that they are effective in reducing healthcare costs.

## $23B
Depression disorders cost employers an estimated $23 billion in lost productivity annually, with depressed employees missing 68 million additional days of work each year compared to their nondepressed counterparts.

## 47.7%
According to recent polling, Americans' exercise habits are on the downslide in 2013, with between 47.7 percent and 53.8 percent of individuals reportedly exercising for at least 30 minutes three or more days per week (depending on the month). Overall, these figures are down from 2012.

*Sources: Gallup Well-Being, Rand Health: A Review of the U.S. Workplace Wellness Market*

# New Drug Approvals: A Case Manager's Guide

**COMPILED BY RICHARD SCOTT**

*This edition of Rx Pipeline, presenting the latest FDA drug approvals, has direct application to case managers and the patients they monitor. For the treatment of depression, hemophilia, lung cancer and more, these drugs are new tools for your mission of coordinating patient care effectively and cost-efficiently.*

## ASTAGRAF XL

**Company:** Astellas Pharma US Inc.
**Date of Approval:** July 19, 2013
**Indication:** Organ Transplant – Rejection Prophylaxis

The FDA approved Astagraf XL (tacrolimus extended-release capsules) for the prophylaxis of organ rejection in patients receiving a kidney transplant with mycophenolate mofetil (MMF) and corticosteroids, with or without basiliximab induction.

"Each transplant recipient is different and requires a personalized treatment approach. The approval of Astagraf XL marks an important milestone in post-transplant care as it provides physicians with a new treatment option for kidney transplant recipients," said Sef Kurstjens, MD, PhD, chief medical officer, Astellas Pharma Inc., in a statement "Astellas is pleased to continue our more than 20-year commitment to the field of transplant immunology."

Astagraf XL is the first once-daily oral tacrolimus formulation available in the U.S. for kidney transplant recipients. Astagraf XL offers a potentially promising treatment option for appropriate kidney transplant recipients as a core component of an immunosuppressive regimen for the prophylaxis of organ rejection.

The two primary, randomized, comparative phase 3 clinical studies to support FDA approval enrolled 1,093 patients in the U.S., Europe, Canada, South America, Australia and South Africa. Astellas was granted marketing approval for tacrolimus extended-release capsules under the trade name Advagraf® in Europe in 2007 and under the trade name Graceptor® in Japan in 2008. Tacrolimus extended-release capsules have been approved in 73 countries.

Astagraf XL can cause serious side effects, including:

• Increased risk of cancer. People who take Astagraf XL have an increased risk of getting some kinds of cancer, including skin and lymph gland cancer (lymphoma).
• Increased risk of infection. Astagraf XL is a medicine that affects your immune system and can lower the ability of your immune system to fight infections. Serious infections can happen in people receiving Astagraf XL that can cause death. Call your doctor right away if you have symptoms of an infection, such as fever, sweats or chills, cough or flu-like symptoms, aches or pain.
• Increased risk of death in females who have had a liver transplant. You should not take Astagraf XL without talking to your doctor if you have had a liver transplant.

## GILOTRIF

**Company:** Boehringer Ingelheim Pharmaceuticals Inc.
**Date of Approval:** July 12, 2013
**Indication:** Non-Small Cell Lung Cancer

The FDA approved Gilotrif (afatinib) for patients with late stage (metastatic) non-small cell lung cancer (NSCLC) whose tumors express specific types of epidermal growth factor receptor (EGFR) gene mutations, as detected by an FDA-approved test.

Lung cancer is the leading cause of cancer-related death among men and women. According to the National Cancer Institute, an estimated 228,190 Americans will be diagnosed with lung cancer, and 159,480 will die from the disease this year. About 85 percent of lung cancers are NSCLC, making it the most common type of lung cancer. EGFR gene mutations are present in about 10 percent of NSCLC, with the majority of these gene mutations expressing EGFR exon 19 deletions or exon 21 L858R substitution.

The FDA's approval of the therascreen EGFR RGQ PCR Kit is based on data from the clinical study used to support Gilotrif's approval. Tumor samples from NSCLC participants in the clinical trial helped to validate the test's use for detecting EGFR mutations in this patient population.

Gilotrif's safety and effectiveness were established in a clinical study of 345 participants with metastatic NSCLC whose tumors harbored EGFR mutations. Participants were randomly assigned to receive Gilotrif or up to six cycles of the chemotherapy drugs pemetrexed and cisplatin.

Participants receiving Gilotrif had a delay in tumor growth (progression-free survival) that was 4.2 months later than those receiving chemotherapy. There was no statistically significant difference in overall survival.

Common side effects of Gilotrif include diarrhea, skin breakouts that resemble acne, dry skin, itching (pruritus), inflammation of the mouth, skin infection around the nails (paronychia), decreased appetite, decreased weight, inflammation of the bladder (cystitis), nose bleed, runny nose, fever, eye inflammation and low potassium levels in the blood (hypokalemia). Serious side effects include diarrhea that can result in kidney failure and severe dehydration, severe rash, lung inflammation and liver toxicity.

## KHEDEZLA

**Company:** Osmotica Pharmaceutical Corp.
**Date of Approval:** July 10, 2013
**Indication:** Depression

The FDA approved Khedezla (desvenlafaxine) extended-release tablets for the treatment of major depressive disorder.

Khedezla contains the serotonin and norepinephrine reuptake inhibitor (SNRI) desvenlafaxine, which is also contained in Pristiq. Pristiq was approved by the FDA in 2008 and contains desvenlafaxine as the succinate salt.

Khedezla will be available in 50 mg and 100 mg strengths for once daily adminitration. Most common in patients treated with Khedezla were nausea, dizziness, insomnia, hyperhidrosis (excessive sweating), constipation, drowsiness, decreased appetite, anxiety , and specific male sexual function disorders.

## ZUBSOLV

**Company:** Orexo AB
**Date of Approval:** July 3, 2013
**Indication:** Opiate Dependence

The FDA approved Zubsolv (buprenorphine/naloxone) sublingual tablet CIII. Zubsolv is indicated for use as maintenance treatment for people suffering from opioid dependence and should be used as part of a complete treatment plan to include counselling and psychosocial support. Zubsolv is a once-daily, sublingual tablet with an advanced formulation of buprenorphine and naloxone that fully dissolves within minutes. Compared with other buprenorphine/naloxone treatments , Zubsolv has higher bioavailability, faster dissolve time, and smaller tablet size with a new menthol taste.

Opioid dependence affects nearly 5 million people across the United States. Although it is a treatable condition only 20 percent of Americans suffering from opioid dependence receive treatment today. Orexo provides with Zubsolv an additional treatment choice with new unique product features that may be important for attracting and retaining more patients in treatment for opioid dependence.

Opioid dependence greatly impacts the U.S. economy, with about $56 billion spent on the disease per year. In addition, the average healthcare cost per patient with opioid dependence is eight times higher compared to non-dependent patients. There is also a great impact on human life, with almost 17,000 deaths from opioid pain relievers in the U.S. every year.

"In addiction medicine, the recovery process can be challenging. Products designed to meet patient preferences have the potential to more successfully support their recovery," said Louis E. Baxter, Sr., MD, FASAM, past president of the American Society of Addiction Medicine, in a statement. "The approval of Zubsolv provides a new treatment option that offers unique advantages specifically designed to meet the unmet needs expressed by patients and has the potential to improve patient adherence, thereby reducing relapse rates and improving successful patient outcomes."

## BRISDELLE

**Company:** Noven Pharmaceuticals Inc.
**Date of Approval:** June 28, 2013
**Indication:** Hot Flashes Associated with Menopause

The FDA approved Brisdelle (paroxetine) to treat moderate to severe hot flashes (vasomotor symptoms) associated with menopause. Brisdelle, which contains the selective serotonin reuptake inhibitor paroxetine mesylate, is currently the only non-hormonal treatment for hot flashes approved by the FDA.

There are a variety of FDA-approved treatments for hot flashes, but all contain either estrogen alone or estrogen plus a progestin.

Hot flashes associated with menopause occur in up to 75 percent of women and can persist for up to five years, or even longer in some women. Hot flashes are not life-threatening, but the symptoms can be very bothersome, causing discomfort, embarrassment and disruption of sleep.

The safety and effectiveness of Brisdelle were established in two randomized, double-blind, placebo-controlled studies in a total of 1,175 postmenopausal women with moderate to severe hot flashes (a minimum of seven to eight per day or 50-60 per week). The treatment period lasted 12 weeks in one study and 24 weeks in the other study. The results showed that Brisdelle reduced hot flashes compared to placebo. The mechanism by which Brisdelle reduces hot flashes is unknown.

The most common side effects in patients treated with Brisdelle were headache, fatigue, and nausea/vomiting.

Brisdelle contains 7.5 mg of paroxetine and is dosed once daily at bedtime. Other medications such as Paxil and Pexeva contain higher doses of paroxetine and are approved for treating conditions such as major depressive disorder, obsessive-compulsive disorder, panic disorder and generalized anxiety disorder. All medications that are approved for treating depression, including Paxil and Pexeva, have a Boxed Warning about an increased risk of suicide in children and young adults. Because Brisdelle contains the same active ingredient as Paxil and Pexeva, a Boxed Warning about suicidality is included in the Brisdelle label.

Additional labeled warnings include a possible reduction in the effectiveness of tamoxifen if both medications are used together, an increased risk of bleeding, and a risk of developing serotonin syndrome (signs and symptoms can include confusion, rapid heart rate, and high blood pressure). Brisdelle will be dispensed with a Medication Guide that informs patients of the most important information about the medication. The Medication Guide will be distributed to patients each time the prescription is refilled.

## RIXUBIS

**Company:** Baxter International Inc.
**Date of Approval:** June 26, 2013
**Indication:** Hemophilia B

The FDA approved Rixubis [Coagulation Factor IX (Recombinant)] for use in people with hemophilia B who are 16 years of age and older. Rixubis is indicated for the control and prevention of bleeding episodes, perioperative (period extending from the time of hospitalization for surgery to the time of discharge) management , and routine use to prevent or reduce the frequency of bleeding episodes (prophylaxis).

An inherited blood clotting disorder mainly affecting males, Hemophilia B is caused by mutations in the Factor IX gene and leads to deficiency of Factor IX. Hemophilia B affects about 3,300 people in the United States. Individuals with Hemophilia B can experience potentially serious bleeding, mainly into the joints, which can be destroyed by such bleeding.

Rixubis is a purified protein produced by recombinant DNA technology. It does not contain human or animal proteins. It is supplied in single-use vials of freeze-dried powder and is administered by intravenous injection after reconstitution with sterile water for injection. When used for the routine prevention of bleeding episodes, it is administered twice weekly.

The efficacy of Rixubis was evaluated in a multicenter study in which a total of 73 male patients between 12 and 65 years of age received Rixubis for routine prophylaxis or as needed in response to symptoms of bleeding (on-demand). Overall, patients in the prophylaxis study had a 75 percent lower annual bleeding rate when compared to patients who have historically received on-demand treatment. An additional study in a pediatric population is currently ongoing.

Although serious side effects including anaphylaxis (life-threatening allergic reactions) can occur, the most common side effects observed in patients in clinical studies were dysgeusia (distorted taste), pain in an extremity, and atypical blood test results.

*Further drug information, including safety information, warnings, contraindications and other facts about general use, is available online at www.fda.gov/drugs.* CIP

# Key Strategies Aim to Boost Specialty Care Access for Low-Income Patients

BY STEVEN DASHIELL

Healthcare reform is meant to increase many lower income individuals' access to the care they need. This is largely being performed through an expansion of Medicaid eligibility, which will widen significantly in 2014.

Though this is intended to help individuals who had zero coverage prior to the Affordable Care Act (ACA), researchers understand that this expanded coverage is not a panacea for all of the gaps in the current healthcare system, particularly for those in low income brackets.

## ACCESSING HARD-TO-FIND CARE

Currently, Medicaid enrollees in many states have a difficult time accessing specialty care and surgical specialty services. In this context, specialty care addresses specific categories of patient health, such as cardiology or oncology. The reasons behind this challenge are many; low Medicaid payment rates, administrative burdens and the everyday challenges placed upon the average Medicaid enrollee make obtaining specialty care especially onerous for such individuals.

A recent study from the Center for Studying Health System Change, conducted by Laurie Felland, Amanda Lechner and Anna Sommers and released by The Commonwealth Fund, reviews a number of approaches and strategies to improving low-income access to this specialty care. Providers within the study employed a range of strategies to combat the problem, suggesting that the vagaries of specialty care and healthcare reform have not yet been fully assessed.

"Currently there's a lot of focus on primary care and preventive care in the Affordable Care Act, and it's hoped that providing more care up front will reduce the need for specialty care down the road," says Felland. "However, as more people go to the doctor under the new coverage, it is likely that more problems will be uncovered, so the need for specialty care is likely to grow."

Felland identified three major approaches used by the providers and organizations participating in the study, each with addi-

> "THIS NEW TYPE OF PROFESSIONAL SERVES AS AN INTERMEDIARY BETWEEN PATIENTS, PRIMARY CARE PROVIDERS AND SPECIALISTS."

tional strategies and tactics that varied on an individual basis.

**Increasing the availability of specialty practitioners.** Making specialty practitioners more available to meet the demand required of Medicaid enrollees is the first approach listed in the study and one that holds promise for areas outside of specialty care as well. Strategies in this approach include the utilization of telehealth, such as video conferencing to connect specialty care practitioners with patients.

**Expanding the role of primary care providers.** Expanding the knowledge-base and skill set of primary care providers could increase the accessibility of specialty care for Medicaid patients and lighten the burden placed on specialty care practitioners. Additional training for primary care physicians offers the simplest solution for expanding this role. One program in the study, Project ECHO, offers videoconferencing training for primary care providers elsewhere.

**Enhancing communication and coordination.** Improving communication and coordination among the patient, primary care providers and specialists can reduce the inefficiencies found in the process of accessing specialty care, opening up additional access opportunities for Medicaid patients. Many of the models in the study created a new staff position, often called the "access coordinator," says Felland. This new type of professional serves as an intermediary between patients, primary care providers and specialists, while also collecting information on the needs of the patient.

Though the programs listed in the study are still in progress and many lack hard data, Felland feels that some approaches may be

more broadly used than others. Enhancing communication and coordination, for example, is a flexible strategy with many implementation options that can be universally applied for most providers, even beyond the needs of specialty care.

Some of the approaches, on the other hand, may provide more challenges. "If you're increasing the availability of specialty practitioners, it can be more difficult to find those specialists and provide reimbursement for their services, or hire and train physician's assistants or new staff," notes Felland. Providers must also ensure a high enough volume of patients needing a particular specialty in order to justify the hiring of new specialists.

## BIG CHALLENGES REMAIN

Like any new program, implementation requires time, testing and funding in order to succeed. Provider buy-in and differences, patient safety and quality of care, and the temporary loss of productivity associated with learning a new skill all must be traversed in order to better provide specialty care to low-income patients. Predictably, funding also remains an issue:

"A big barrier in these strategies is a lack of reimbursement from Medicaid for a lot of these strategies. Many don't involve face-to-face visits, whether it be telehealth or eReferrals or access coordinators – a lot of these support pieces are not part of the regular way that Medicaid reimburses," says Felland.

These studies press on, however, both for specialty care and beyond. Felland concluded that further study of the impact of these strategies would help assess whether they would be useful in other settings and with other types of patients.

"There's an expectation, or even a leap of faith, that [the models] will help people get care in a timely way and reduce hospitals admissions, ED use and increase coordination of care, but it's hard to track these changes. It's hard to measure them," says Felland. "I think that to whatever extent that formal evaluations can be performed will be greatly useful in accomplishing these goals." CIP

# Weighing the Benefits of Telehealth: Conquering Challenges, Opening Opportunities

BY STEVEN DASHIELL

Telehealth has been under increased study as a method of boosting patient satisfaction, lowering the burden placed upon patients in remote areas and enhancing patient engagement with physicians. At its best, telehealth holds the potential to open lines of communication that had previously been difficult to establish.

However, the benefits of telehealth bring with it a series of risks and unknowns – what procedures or conditions are appropriate to practice telehealth versus an in-office visit? Can a patient's own estimation of health and their condition stand in for the experience and knowledge of a physician's examination?

A recent study from Stanford University School of Medicine reveals that telehealth can indeed stand in for postoperative clinic visits for certain procedures.

### THE CHALLENGES OF TELEHEALTH

Telehealth presents a number of issues for implementation into actual practices. These challenges are not always visible until work begins on implementation or early results can be measured. The NHS Confederation, a membership body for the England-based National Health Service (NHS), ran into these challenges when exploring the possibilities of expanding their telehealth and digital medicine services. The Confederation broke these issues into three basic categories:

**Power and Identity.** The removal of face-to-face conversation between physician and patient can have subtle effects on the relationship between the two. By being represented as "just an image" on a screen or a voice over the phone, both parties stand to be de-personalized, affecting their perceptions. It can be difficult to empathize with a patient when a layer of technology and many miles stand in between the physician and the patient who has personal, unique needs and care requirements.

**Trust.** The installation of a telehealth service in a patient's home requires an immense amount of trust between patient and physician. Beyond basic issues of privacy, it is difficult for patients to know just who is taking care of them with certain telehealth systems. The NHS Confederation notes an example of a patient equipped with teledermatology feeling unease when their usual doctor visit was replaced with a nurse with a digital camera – the patient had little interactions with this nurse and few ways of influencing the encounter.

**Equity.** Beyond a separation of power and equality of physician and patient, telehealth also faces socioeconomic hurdles. Access to the technology required for telehealth can vary widely based on location. General technological literacy also ranges based on location and age of the population. The Confederation notes that often "those with the greatest need for information about health are least likely to have access to it."

### STARTING SMALL

Though promising telehealth programs have performed across the U.S. for objectives such as monitoring blood pressure or insulin levels in patients, Stanford University School of Medicine is among the first to test the efficacy of telehealth encounters for postpoperative clinic visits in ambulatory surgical procedures. The severity of the procedure and potential for harm in a failed postoperative diagnosis caused Stanford to start small with their study, eliminating a number of previously listed challenges and distilling the telehealth experience down to a simple phone conversation between physician and patient.

Patients who agreed to the study were all scheduled for either elective open hernia repair or laparoscopic cholecystectomy and had appointments for typical postoperative clinic appointments three weeks after the procedure. Patients were called two weeks prior to the clinic appointment by a physician assistant and questioned on the following: overall physical well-being; persistent pain and use of analgesics; fever or chills; appearance of the incision; discharge from the incision; swelling/redness of the incision; testicular swelling or pain (for hernia repair); activity level compared with baseline; appetite compared with baseline; normal bowel movements; additional patient concerns.

Patients who were determined to be making a poor recovery, measured by signs congruous with the transcript questions, such as worsening pain in spite of analgesics or signs of infection, were told to follow through with their scheduled clinic appointment. However, if no signs of poor recovery were found and both the patient and physician were satisfied with the telehealth call, then the clinic appointment was deemed unnecessary and the postoperative follow-up was considered a success.

### RESULTS

Of the 141 patients who underwent qualifying procedures for the study over the 10-month test period, 89 of 115 hernia patients and 21 of 26 laparoscopic cholecystectomy patients were contacted by phone. Sixty-three of these hernia patients and 19 of these laparoscopic cholecystectomy patients elected to perform their postoperative visit via telehealth instead of an in-person clinic visit.

Though determining cost savings was not the aim of the study, it is thought that a 10-minute phone call with a physician assistant versus a five- to 10-minute visit with a surgeon would see a decrease in overall costs, according to the study. However, the primary goal of the study yielded positive results, increasing efficiencies and satisfaction for patients and the physicians treating them. A careful, measured transition to telehealth may be an effective way of saving time, treating a greater number of patients and cutting costs, all performed with the simplicity of a telephone call. CIP

# Practicing What We Preach: Taking Strides to Improve Case Manager Health

### BY TERESA M. TREIGER, RN-BC, MA, CHCQM-CM, CCM AND BARBARA HARDING, RN, MPA, CCM, PAHM

Case management's underlying philosophy is that "when an individual reaches the optimum level of wellness and functional capability, everyone benefits."[1] In the flurry of activity to advocate, communicate, educate and navigate as a member of our client's care management team, we may be losing sight of our own health and well-being and its impact on our clients.

This article provides the perspectives of two experienced case managers regarding the journey toward better health and wellness. By sharing our stories, our hope is that you will be prompted to consider assuming a more active approach to your personal health and subsequently improve your interactions with clients challenged with making lifestyle changes.

More than one-third of adults, and almost 17 percent of youth in America, were obese in 2009-2010.[2] Medical treatment plans often include interventions that address diet and exercise. It should have come as no surprise when the American Medical Association recently adopted a policy recognizing the impact of obesity on health by designating it a disease.[3] Case managers are knowledgeable about the impact of smoking, substance abuse, lack of exercise, and obesity on health and wellness.

So why is it that two intelligent women, knowledgeable about health and wellness, did not practice what they preached to their clients? Perhaps a glimpse into

our personal stories (see sidebars) will shed light on the reasons.

## A FEW SOBERING STATISTICS

Informal surveys were conducted by Ascent Care Management between January and March 2013[4] focused on how case managers viewed their health status in relationship to diet and exercise. Basic respondent demographics are provided in Tables 1, 2, and 3.

The survey posed questions relating to physical activity during work hours and employer-supported fitness benefits. When queried as to how much continuous sedentary time was spent at work, responses demonstrated a significant amount of inactive time.

It is significant to see the impact of the work environment on inactivity. Respondents often worked in an office setting. Given the scope of responsibility and performance expectations, it appeared to be difficult to incorporate regular periods of physical activity into the workday because over 50 percent of the respondents reported being sedentary for greater than 6.1 hours of their workday. When asked about taking time for weekly exercise of at least 30 minutes, 45 percent of the respondents reported that they did not exercise.

Perhaps most concerning is the apparent lack of employer-supported health and fitness benefits. Responses to the question, "Does your company have an onsite exercise pro-

gram, gym or fitness benefit (e.g., gym membership, incentive discount, access to wellness coaching)?" were disheartening when taking into consideration the fact that respondents work predominantly for healthcare providers or in healthcare-related settings.

Finally, when asked, "Has you healthcare provider recommended that you lose weight?" 32 percent reported that it had been and that they had done so. However, there were 24 percent to whom weight reduction had been recommended but who had not taken any action to do so. The lack of initiative to make lifestyle

**Table 1**

| Age range | | |
|---|---|---|
| | Percent | Count |
| 18 to 24 | 0.0% | 0 |
| 25 to 34 | 0.0% | 0 |
| 35 to 44 | 12.2% | 5 |
| 45 to 54 | 48.8% | 20 |
| 55 to 64 | 36.6% | 15 |
| 65 to 74 | 2.4% | 1 |
| 75 or older | 0.0% | 0 |

**Table 2**

| Gender | | |
|---|---|---|
| | Percent | Count |
| Female | 97.6% | 40 |
| Male | 2.4% | 1 |

## Barbara's Journey: Inching to Empowerment

In 2009, my mother's health was failing. As I looked at her, I thought of my future, my health. Many of the chronic disease conditions she had, hypertension, cancer, diabetes and ESRD, I was beginning to deal with. Most concerning was my HgbA1c as it began to rise. I saw what she had been through and I knew this was could be my future if I didn't make some serious lifestyle changes.

I also didn't want to be a hypocrite. There is something about a health professional that is teaching or talking about health while not practicing what they preach. How could I expect the population that I manage to make changes and not do so myself? How could I empower someone to make a difference in their health if I wasn't taking care of mine?

So it was at that moment that I made the commitment to myself to change my future. I began slowly. I focused on exercise and just moving or as my friend says to me, "Let's wiggle!" I established small

goals and focused on their achievement. Eight months after I began to exercise, I completed my first 10K. Was it hard? You bet. But the reward of participation and completion made it worthwhile.

Changing my eating habits came next. Like many, I have tried all kinds of diets and programs. This time, I decided to try Weight Watchers online. In February I celebrated keeping 50 lbs. off for one year. I continue to hold myself accountable by continuing to track my intake and weight.

Through this experience, I have better insight into my patients and their behavior. I have found that maintaining healthy choices isn't easy. Each day I must be focused and take deliberate action as it relates to diet and exercise. As I work with others, I can speak with a voice of encouragement to empower and build confidence. The reward of having someone tell you that you have inspired them gives one pause to celebrate the success and the fortitude to continue the journey to better health.

## Teri's Journey: Overcoming the Odds

I am cursed with a genetic nightmare of obesity predisposition on both sides of my family tree. Issues of weight management plagued me for my entire life. In addition, food had become my drug of choice relative to relieving the stress created by work and events of my life. Mind you, my inability to make permanent lifestyle changes was not for lack of trying. Contrary to what some people believe to be a lack of will power, I have gained and lost and gained back hundreds of pounds. I purchased enough exercise equipment to fill a gym and that does not include the health club memberships I have had over the years. It seemed that whenever I returned to "regular" eating habits, all of my hard work was undone.

It was an ankle injury in my late 40s that forced me into a series of splints and casts which necessitated extensive periods of nonweight-bearing and ultimately required two surgeries over a three-year period to resolve. During the downtime, I became so deconditioned that I was barely able to climb a flight of stairs without my heart racing to the point that I almost passed out.

While none of my biomarkers (e.g., HbA1C, lipids, cholesterol, blood pressure) were out of normal range, life looked pretty grim. In thinking through my options of how to address the challenge, I decided that I had to case manage myself. In other words, to put myself through the same case management process that I use with my clients.

This approach required brutal honesty in order to examine the causes of my overreliance on food and to develop interventions of real meaning and impact. I gained a much better understanding of what it was I asked clients to do and realized that if I was not walking the walk, I had no real business asking others to take the same steps toward better health and wellness. After losing a significant amount of weight, the losses slowed, finally coming to a grinding halt for the past 12 months. In order to lessen the profound discouragement I was experiencing, I shifted my focus from weight loss to fitness. Presently, I "jalk" six to seven days a week for periods ranging from 45 to 90 minutes. (In case you were wondering, "jalking" is my own term for the combination of walking and jogging.) And so my journey continues.

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change is similar to findings of Miller et al. in that 53 percent of study subjects (nurses) that were overweight were not taking steps toward lifestyle change.[5] If healthcare professionals do not take action to make a lifestyle change, how can they motivate patients to make meaningful changes in their own?

### DEVELOPING SELF-LEADERSHIP

There is no time like the present to evaluate your health, develop a strategy and put it into action. If we do not address our individual and collective health shortcomings, we compromise our ability to provide genuine healthy lifestyle recommendations to our clients when we are not optimally healthy ourselves. Use the case management process and make it work for you.

Remember, this is a learning process. We are continuing to learn about ourselves, what works and what does not. We hope that by sharing our journey and what we have learned that you will be inspired to join us on this journey. We look forward to hearing from you to cheer you on or to celebrate your success. Here's to our health. CIP

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**Table 3**

| Work Setting | | |
|---|---|---|
| | **Percent** | **Count** |
| Accountable care organization | 0.0% | 0 |
| Acute hospital | 36.6% | 15 |
| Ambulatory (e.g., clinic, FQHC) | 0.0% | 0 |
| Assisted living facility | 0.0% | 0 |
| Health insurance (e.g., indemnity, HMO) | 26.8% | 11 |
| Long term care | 0.0% | 0 |
| Patient-centered Medical Home | 0.0% | 0 |
| Rehabilitation hospital | 2.4% | 1 |
| Skilled nursing facility | 0.0% | 0 |
| Worker's compensation or disability management | 4.9% | 2 |
| Other (please specify) | 29.3% | 12 |

# Integrated Case Management: Promoting Quality in a New Era

## How assessment tools, interviews and other resources improve patient care

BY JULIE O'BRIEN, BSN, RN, MS

Integrated healthcare is becoming the new buzzword of the health and wellness industry. The concept takes a prevention and education approach, maintaining a certain level of health, managing disease and maintaining normal medical concerns. Case managers can be an integral part of navigating patients on their journey to getting well and staying well, adhering to care plans and answering questions regarding their health. They must also look at how to best manage existing conditions, along with utilizing available tools on the road to a healthy lifestyle.

Often, the abundance of integrated health tools can be a deterrent for patients who lack expertise with technology or who are afraid to learn something new. Having a partner or coach in a care management nurse can help to chart a healthy course for the patient. Having a guide who will take the time to help them understand how to use a tool will change the patient's outlook toward compliance and better overall health.

One of the more exciting developments in recent years is the growing availability of evidence-based risk assessment tools and other data sources to build an individualized care treatment plan that controls for the co-morbidities of each patient. Case managers can collect information through health-risk assessments, patient interviews, clinical data or other sources, and identify risk factors for each patient through their medical management system, which assists them in creating an action plan that combines prevention, education and treatment protocols, all while building a relationship with the patient.

With so many aspects of care coordination to think about, case managers need a care management system they trust to help them assess, plan, implement, track, facilitate and document key aspects of a patient's care. Utilizing assessment tools and resources available to provide integrated care plans for patients with both patient and caregiver access is of paramount importance in getting patients well and keeping them well.

### A NEW LOOK AT LIFE COACHING

For 85 percent of Americans, taking steps to be healthy on a daily basis is not one of their favorite things to do. The healthcare system needs to move in the direction of behavior modification if it hopes to lower the incidence of chronic disease and get our population healthy and keep them that way. Finding personal motivators for patients is a unique skill. New care management training programs focus on the life coaching approach to care management; this encourages patients to open up about what makes them happy, what they live for and what they hope to do in future years. The ability to be alive and

> "CASE MANAGERS NEED A CARE MANAGEMENT SYSTEM THEY TRUST TO HELP THEM ASSESS, PLAN, IMPLEMENT, TRACK, FACILITATE, AND DOCUMENT KEY ASPECTS OF A PATIENT'S CARE."

well to see those life goals to fruition can be a major motivator.

Many healthcare professionals believe care management needs to start at the pediatric level in order to impact the future of health in America. By educating patients of all ages and encouraging health-enhancing behaviors, case managers can achieve a major goal, providing the tools and resources to combat unhealthy habits and behaviors, while reminding patients why they want to do it in the first place.

This type of behavioral change model has become a primary objective in healthcare, as preventive care and lower readmissions are seen as a key indicator of success in managing chronic illness. Many chronic conditions are caused by certain habits or behaviors (smoking, drinking, lack of exercise, increased stress levels and poor diet). Educating, supporting and encouraging patients with health-enhancing behaviors to move toward the goal

of decreasing unhealthy habits and behaviors will decrease the number of chronic diseases that are a result of the behavior – thus, preventing the problem before it occurs. But keeping them motivated and on task may be the bigger issue.

Counseling on such topics as quitting smoking, losing weight, eating healthfully, treating depression and reducing alcohol use, as well as engaging patients across the care continuum, will assist in the goal of a healthier population. A greater emphasis on nontraditional treatment as part of a care plan has increased the need for tools that sort through evidence and studies, providing evidence-based research even for nontraditional therapies, such as yoga, massage, Reiki, music therapy and prayer. Care management professionals are taught to be open-minded when it comes to helping their patients assess their needs and review their health – mind, body and soul.

While sorting through the various aspects of integrated healthcare may be overwhelming, there is no doubt that integrated healthcare and care management is here to stay. Creating a culture of patient-centered, needs-based, collaborative care plans is an altruistic way to reach the goals supported by healthcare reform.

When patients, physicians, nurses and coaches work together toward one common goal starting at an early age, patients can achieve their goals, which often include longevity and a healthy quality of life. CIP

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# Nurses on the National Stage: Leading the Charge to Better Health Outcomes

BY ROBIN A. KIMMEL, BSN, RN, CCM, AND KATIE M. HALL, RN

*In March 2013, under the guidance of Ms. Teri Mills, MS, RN, CNE, several registered nurses visited Washington, D.C., to seek legislative support for H.R. 485. This effort included the authors and other nurses who represent the National Nursing Network Organization (NNNO) as members of the advocacy team. The participants had the opportunity to add their voices to the support for a National Nurse for Public Health, visiting with stakeholders and gatekeepers of the legislative process. It became evident that nurses are important to the political process and can effectively use their voices to influence policy change that will benefit the public's health.*

## ABSTRACT

With the rate of preventable conditions on the rise, healthcare costs reaching unsustainable heights and more than 50 million Americans who remain uninsured, the need to restructure the healthcare system has never been more evident. Nurses are the key to redesigning healthcare, but currently there is not one nationally recognized nurse to lead nurses and other health professionals in this effort. Nurses are essential to the political process and can effectively use their voices to promote policy change that improves the nation's health. Supporting and passing H.R. 485, the National Nurse Act of 2013, would assign the Chief Nurse Officer of the U.S. Public Health Service, within the Office of the Surgeon General, to be further known as the National Nurse of Public Health. This nurse will help engage and involve nurses in health promotion and disease prevention.

Nurses, as healthcare providers and consumers, feel the impact of a healthcare system in crisis. They are challenged to remain current with the plethora of research-based evidence that guides practice as they are inundated with the day-to-day duties of patient care and the politics of the organizations where they work. Nurses are overwhelmed with pressure to achieve higher levels of education; the constant struggle to ensure safe staffing ratios; and increasingly complex patient cases due to the rise of preventable illness.

Chronic diseases affect the entire nation, excluding no ethnicity, demographic or socioeconomic group and are, more often than not, preventable. Chronic disease is responsible for most health conditions, suffering and untimely fatalities that ultimately lead to 70 percent of recorded deaths, affecting approximately 133 million Americans

each year (PFCD, 2009). The care and management of chronic disease accounts for three-quarters of the total annual healthcare expenditure and impacts the nation's economy by decreasing productivity and economic growth. The rising cost of Medicare and Medicaid are linked to the increased rates of chronic preventable disease and contribute to approximately 18 percent of the gross domestic product (PFCD, 2009).

Adult obesity has become a major health issue in the U.S., resulting in a variety of conditions, including diabetes, cardiovascular disease, stroke, hypertension and dyslipidemia (Eckel, Kahn, Robertson & Rizza, 2006). Chronic diseases and obesity amongst children have quadrupled over the last four decades and this trend is expected to continue (Shaya, Flores, Gbarayor & Wang, 2008). Type 2 diabetes is on the rise and is so prevalent that it is now considered an epidemic (Mainous et al., 2007). The use of tobacco remains the single most preventable cause of disease and early death in the U.S., yet nearly one in five adults continues to smoke (ACS, 2012). Acute outbreaks of influenza, acute respiratory infections

and highly transmissible infectious diseases continue to threaten public health (Stirling, Littlejohn, & Willbond 2004). Health disparities prevail as minority groups continue to have higher incidence of chronic diseases, greater barriers to healthcare access, lower socioeconomic status and health literacy, and are at increased risk for chronic and acute disease (Liao et al., 2011; Zhu et al., 2011).

Increased healthcare costs, health disparities and low health literacy, combined with the rise of chronic preventable conditions, demonstrate that current efforts to improve health are inadequate. To improve healthcare and reduce healthcare costs in the U.S., the

## "THE NURSING PROFESSION HAS BEEN CALLED UPON TO TAKE A LEADERSHIP ROLE."

healthcare system must be transformed into one that focuses on health promotion and wellness, disease prevention, and chronic illness management. Well-designed programs of disease prevention implemented in communities, schools and the workplace can reduce the economic burden and increase healthy lifestyles and assist with modifying health risk behaviors so that the trend toward costly acute and chronic diseases can be reversed (CDC, 2010; PFCD, 2009).

### NURSING AT THE FOREFRONT

The American Nurses Association (ANA) (2001) Code of Ethics stated, "The nurse collaborates with other health professionals and the public in promoting community, national and international efforts to meet health needs" (provision 8). The Institute of Medicine (2010) noted that "Nurses should be in full partnership with physicians and other healthcare professionals in redesigning healthcare in the United States" (p.1-8). The Robert Wood Johnson Foundation (2010) reported that 86 percent of opinion leaders would like to see nurse professionals lend their expertise to influence the promotion of health and wellness, and enhancement of

preventive care initiatives, be involved in health policy development and make use of their experience through influence in healthcare policy. Further, these leaders convey the acknowledgement that the nurse's skill, knowledge, and expertise is essential to improve the provision of healthcare and public health. Clearly, the nursing profession has been called upon to take a leadership role in healthcare reform and to take an active position in full partnership with those involved in health policy development and the transition to focus on preventive care.

Nurses can offer expertise, knowledge and commitment in the political arena by providing a strong voice for quality healthcare (Nault, 2012). Gallup polls show that the public trusts nurses more than any other profession because they are recognized as ethical and honest. Nurses comprise 80 percent of the healthcare workforce, work closely with patients and physicians, have scientific knowledge of the patient care processes and occupy a prime position to enhance and strengthen preventive programs because they are on the frontline of prevention and health promotion (Lazarou & Kouta, 2010). They are experts in organizing and delivering care, yet they are often excluded from planning healthcare policies and programs (Kennedy, 2011).

With passage of the 2010 Affordable Care Act, nurses are in a position to lead change and advance care. In order to improve healthcare and reduce healthcare costs in the U.S., the foundation of the healthcare system must focus on disease prevention, health promotion, and wellness and chronic illness management (Chaffee, Mason & Leavitt, 2011).

Teri Mills, President of the National Nursing Network Organization (NNNO), is determined to change this by calling for nationwide nurse leadership provided by a National Nurse for Public Health through legislation currently in Congress, H.R. 485, the National Nurse Act of 2013. The NNNO, a grassroots organization, has supported and campaigned for H.R. 485 uniting nurses across the nation to raise awareness of the nursing profession's and public's demand for national nursing leadership and emphasize how critical nurses are to the reformation of our nation's healthcare system.

H.R. 485, introduced by Representatives Eddie Bernice Johnson (D-TX) and Peter King (R-N.Y.), would amend the Public Health Service Act. This legislation will designate the Chief Nurse Officer of the U.S. Public Health Service, within the Office of the Surgeon General, as the National Nurse for Public Health. The National Nurse for Public Health will continue to partner with the Surgeon General and provide strong leadership, strengthen nursing programs and nursing's role within the public health infrastructure, and will help engage and involve nurses in health promotion and disease prevention. H.R. 485 will encourage and strengthen nursing relationships between health-related national organizations and state and local communities and will disseminate health promotion information for improving public health through community action (Johnson, 2013).

Congresswoman Johnson's comments about H.R. 485 summed up the importance of a National Nurse for Public Health when she stated,

*"Having worked as a registered nurse, I know firsthand the critical role nurses play as patient advocates. Just as nurses and physicians work together to care for patients, so should they collaborate to promote health. The National Nurse for Public Health would support and expand on the work of the Surgeon General, while helping it to reach a wider audience. Nurses are some of the most trusted professionals in the country, and the National Nurse for Public Health would be in a unique position to promote prevention and healthy living through education, community service, and media" (Personal communication, April 30, 2013).*

H.R. 485 is an innovative and pragmatic solution that will engage, motivate, and unite nurses in the focus on disease prevention in congruence with the mission of the Office of the Surgeon General and the National Prevention Strategy (U.S. Department of Health & Human Services, 2013). H.R. 485 has enormous potential to benefit and positively impact public health, the nursing profession, as well as the economic predicament of the healthcare system (Van Betten, 2012).

Nurses have always responded to the priority health needs of society by serving individuals, families, groups and entire communities (American Public Health Association, 2012). By uniting nurses through the efforts of a National Nurse for Public Health, nurses will continue to positively impact the reduction of healthcare costs and improve the quality of life for Americans by encouraging disease prevention and promoting healthy lifestyles. By appointing a National Nurse for Public Health, who will be at the forefront of healthcare reformation with a focus on health promotion and the prevention of illness, chronic preventable conditions will decrease and the health of the nation will improve (Van Betten, 2012). The National Nurse for Public Health will represent nurses in the identification of and attention to national health issues and will enhance and organize illness prevention and health improvement initiatives (Mills & Schneider, 2009).

America is in the midst of several health epidemics. The quandaries of obesity, chronic and acute disease, access to healthcare, healthcare illiteracy, healthcare disparities and unhealthy lifestyles will not solve themselves. It is time for nurses to have support from a National Nurse for Public Health who will be a full-time, publicly recognized nursing leader who represents and empowers nurses on a national level, collaborates with other healthcare leaders, advocates for healthcare reform and nurse involvement in healthcare policy, and ultimately strengthens nursing's role in healthcare issues. CIP

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# Sparking Engagement Among an Aging Workforce
## Tools and strategies that stimulate wellness among workers

BY NINA M. TAGGART, MA, MD, MBA, FAAO, AND MARK UNGVARSKY

As our population ages, particularly the baby boomer generation, the natural result is an aging workforce. In fact, the Bureau of Labor Statistics projects that by 2015, 31.9 million workers – or nearly 20 percent of the total labor force – will be over the age of 55. As more people choose a second career, or postpone retirement, whether by choice or necessity, a multigenerational workforce has become the norm.

While this may be beneficial from the standpoint that older workers tend to be more experienced and can provide insight and leadership through that experience, the flip side is that the older we get, the more likely we are to have a chronic condition or other illness that can decrease productivity. Studies (Paez et al.

*Health Affairs*, January 2009) have shown that the incidence of heart disease more than doubles in patients over the age of 45. For diabetes, it more than triples. It is no wonder that, according to the Centers for Disease Control and Prevention, more than 75 percent of all healthcare costs are related to chronic illnesses. And according to a recent Gallup poll, unhealthy workers are costing U.S. employers more than $150 billion annually.

At AllOne Health Management Solutions (AllOne Health), our experience shows that the costs related to chronic illnesses are often related to poor lifestyle choices. Smoking, a lack of physical activity and unhealthy eating are just some of the lifestyle choices that can lead to chronic illnesses.

So the question becomes: How do you change those poor lifestyle habits to ensure that all workers – and older workers in particular – remain healthy and productive?

### OLDER WORKERS AND WELLNESS
When testing for statistical significance within an age group and between age groups, we found differences in how older and younger workers view wellness, and in what their attitudes are about the lifestyle choices that influence well-being. Our analysis was performed using the University of Michigan Health Assessment that captures information on 17 medical conditions, as well as mental health, productivity health risks and biometric data. The health assessments were completed by more than 6,000 individual AllOne Health members. Results were further classified as over and under age 55.

Three key findings emerged from the analysis:

1. Wellness correlates positively with physical activity.
2. Wellness correlates positively with self-reported productivity.
3. Wellness correlates positively with job satisfaction.

On the first finding, wellness correlates positively with physical activity, we also found the correlation to be stronger with age. The difference between the younger and older group was in fact highly statistically significant for the oldest age group. This suggests that older workers understand the value of physical activity as it relates to their overall wellness. Perhaps this is due to older workers trying to "keep up" with their younger counterparts, or the realization that as we get older, we have to work harder to keep in shape.

The second finding, wellness correlates positively with self-reported productivity, also strengthens with age. The difference between the younger and older group is highly statistically significant for the oldest age group, meaning that older workers make a very clear connection between how well they feel and how productive they are.

The third finding, wellness correlates positively with job satisfaction, is not as strong a correlation with age. However, the difference between the youngest and oldest workers is statistically significant. Older workers do feel more satisfied with their job and have the ability to be more productive when they are feeling healthier.

In addition we found that stress negatively affects self-reported productivity for all age groups. While older workers are often able to handle stressful situations more appropriately, there is room to enhance organizational performance across spans of young and older workers through more advanced intergenerational, organizational resilience programs.

Physical health does, in fact, affect productivity and the correlation grows stronger with age. Younger workers are more likely to come in to the office when they feel sick to complete tasks while older workers are more likely to stay home when they feel sick. Solutions that allow for flexible work locations and sched-ules enable organizations to maintain or improve productivity and performance.

## RESULTS: RISK FACTOR MODIFICATION

Strong wellness programs center on proactive health risk and productivity management. In our study, the AllOne Health program has made a statistically significant impact on the reduction of risk factors across all age groups after only one year. In our analysis, risk factors are stratified as low risk (one to two risk factors), moderate risk (three to four risk factors) and high risk (five or more risk factors).

Using health assessment results from one year to the next, the number of older workers (55 or older) identified as high risk decreased by 16 percent. The number of older workers identified as moderate risk decreased by 24 percent, and the number identified as low risk increased by 12 percent. Through care management and wellness interventions, we achieved the goal of moving our older members down from higher to lower risk categories and kept healthy members at low-risk levels.

## MOTIVATING OLDER WORKERS FOR WELLNESS

In the process of changing poor lifestyle habits, the next challenge after identifying the risk factors is motivating the individual to change. Health coaches work with individuals to create personalized health and wellness plans to address their risk factors. Disease and case management programs also help individuals with chronic illnesses better manage their condition.

To further evaluate the findings from the health assessments, we informally surveyed our coaching staff on their observations on dealing with differences among coaching older and younger workers. Our AllOne Health coaching staff includes registered nurses, dieticians and exercise physiologists with an average of 15 years of clinical experience, who are trained in motivational interviewing, a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.

Our health coaches determined that the differences between younger and older workers were striking around locus of control, view of the doctor-patient relationship, acceptance of health coaching and communication pref-erences. Interestingly, despite the acknowledged impact of wellness, older workers are not as focused on healthy lifestyle choices as younger workers. To combat this, health coaches must work to reframe the health beliefs of older workers and introduce self-management ideas, tools and resources.

When asked about the locus of control (whether or not the worker feels that they are in control of their own choices because of many conflicting life priorities), our health coaches found that younger workers are more open to new information and ideas for change. When working with younger workers, the approach can be more direct while still being more sensitive to the delivery of the message than with older workers. Older workers, conversely, need a less direct approach. Listening more and moving at the older worker's pace with empathy and compassion has proven to be more successful.

As for the doctor-patient relationship, younger workers consider our health coaches to be credible health professionals and partners in health and wellness along with their doctor. Older workers tend to view their doctor as the "captain of the ship," so our health coaches work to support that relationship and help to ensure that older workers are staying on a healthy path and following their doctor's advice with regular check-ups and recommended screenings.

Finally, our health coaches found that motivating towards a goal or a reward was most successful with older workers. Rewards that motivate the older worker include maintained independence, a longer life, time with grandchildren or time for travel.

## TAKEAWAYS: TIPS FOR MOTIVATING THE OLDER WORKER

Consider the sports metaphor of the aging athlete. With athletes, aging leads to performance pressure, which leads to a negative effect on performance that continues to spiral downward. In short, the athlete recognizes that the gap is widening between what was and what is.

The same can be said about aging workers. They feel pressure to keep up with younger colleagues that can lead to a negative effect on performance and the same downward spiral. Intergenerational training and resiliency through coaching programs help the aging

# Unresolved Conflict: The Leading Culprit Behind Healthcare Burnout?

**BY STEVEN DINKIN, BARBARA FILNER AND LISA MAXWELL**

Being a healthcare professional is not for the faint of heart. The work itself is physically and emotionally draining. Doing that work in a fast-paced and often understaffed environment dials up the stress level even higher. Finally, add in the massive changes sparked by healthcare reform as organizations strive to comply with new regulations and, in general, do more with less. No wonder nerves are frayed, tempers are short, and conflicts with co-workers boil up from time to time.

In case management not only are collaboration, facilitation and communication essential, they are also critical to managing conflicts properly and resolving them positively. Managing conflicts that naturally occur as part of case management can therefore be seen as a necessary and vital skill for case managers.

## BENEFITS OF CONFLICT RESOLUTION

In healthcare, of course, unresolved conflict can have very negative consequences for patients. But conflict resolution is also important from a workplace satisfaction standpoint because it can reduce employee burnout and turnover rates, help with recruitment, and ensure that the best employees are more likely to stay.

My new book, along with coauthors Barbara Filner and Lisa Maxwell, *The Exchange Strategy for Managing Conflict in Health Care,* puts healthcare leaders back in the driver's seat of their organizations. It's a "go-to guide" that details the four-stage conflict resolution process also known as "The Exchange." This process is derived from the mediation and conflict resolution practices used for 30 years at the National Conflict Resolution Center.

The Exchange combines a proactive, step-by-step process with unique communication skills that together produce positive results. Through it, facilitators can work with staff members and patients to disarm challenging emotions, model interest-based understanding, and lead joint problem-solving collaborations.

## LEADERSHIP SKILLS

Now let's explore why having a conflict resolution structure in place is essential for creating positive healthcare work environments and reducing burnout.

It provides valuable training leaders probably wouldn't otherwise receive. The National Conflict Resolution Center's mediation trainers have recognized that it is not necessary to be a professional mediator to make use of the key communication skills of good mediators. These skills can be taught and learned by most individuals who are interested in learning them. And that is exactly what Exchange training seeks to do.

We have found that healthcare professionals are like professionals in other fields – their training typically did not include training in conflict management. The sad truth is that those most skilled in their professional jobs are not necessarily skilled in dealing with colleagues, employees, supervisors or others. And, as has been widely recognized, many healthcare professionals are trained to be successful – too much depends on their success for it to be any other way – and so it is particularly difficult for them to acknowledge performance that is less than perfect.

When they feel helpless in the face of conflict, whether they're directly involved in it or seeking to mediate between other parties, it will quickly lead to the exhaustion, irritation and cynicism that cause burnout. When Exchange training is present, it provides leaders with essential help in the areas of emotional intelligence, relationship-building, and collaborative practices, enabling them to handle conflict with as much proficiency as they do their medical specialty.

It gives employees a much-needed sense of control. The very nature of healthcare is high stress. Patients depend on you to keep them healthy or to make them feel better. Your colleagues depend on you to do your part to keep patients and other staff members happy so that their jobs don't become any more difficult. But in addition to the stress that comes with these responsibilities, many people in

healthcare must also deal with the fact that at any moment a misunderstanding or miscommunication could derail their whole day.

When The Exchange structure exists, healthcare employees get control over their day. They get confidence. They know that if a conflict does occur they're equipped with the tools they need to handle it. Often, burnout happens because you feel like you just don't have any control over your circumstances, and nothing can bring that feeling on more quickly than a conflict that has spiraled out of control. Exchange training makes employees feel less helpless. They know that when a conflict arises it can be successfully resolved before it completely wrecks co-worker relationships.

It benefits patients, too. For more than a month, a patient had been receiving care from a hospital where he was also a major donor. During his stay, he had several roommates, and his current one was a problem. The roommate, who appeared to have dementia, argued with people who weren't there. He was so loud that the other patient couldn't sleep. This patient put in a room-transfer request, which was endorsed by his doctor, but the nurses hadn't moved him. He felt his request had been deliberately ignored.

The hospital's patient relations representative began implementing The Exchange. She spoke with the night nurse supervisor and found another exhausted person. The hospital was undergoing construction, and this, along with an unusually large patient load, was taking a toll on the nurses. The night nurse supervisor explained that under normal circumstances the room change request would have been easily accommodated, but that day there had been 15 admissions, and she didn't even have beds for all of them.

In the end, the patient and the night nurse supervisor agreed to meet. Both apologized and explained their feelings about the situation. They discussed how to make future communications easier between nurses and patients. Since then, a new intercom system

has been installed that allows patients to immediately communicate their needs to staff. In addition, as a result of the joint meeting, the hospital instituted a patient ombuds program, which requires that all ombuds be trained in The Exchange process.

By handling the conflict between the patient and the night nurse supervisor using The Exchange, not only was the hospital able to resolve the conflict, it was also able to implement positive improvements to prevent similar conflicts in the future and guarantee better care for patients. When employees know that positive resolutions can be reached following a conflict, it prevents them from spiraling into burnout.

It establishes better communication in general. From learning how to respond respectfully to how to listen effectively, when staff members are trained to appropriately handle conflict, they're equipped with better communication skills. In fact, after receiving Exchange training, 91 percent of participants agree that team communication is better.

These skills certainly are essential when a problem arises, but they also make day-to-day communication in a department better, another factor that can reduce burnout.

Improved communication is going to pay off when you're fighting burnout as well. On a basic level, when team members communicate better, they work better together, which makes for a better work experience.

It builds trust and respect among your teams. When staff members and teams can communicate effectively with one another, it is much easier for them to see their colleagues' strengths. As a result, trust and respect grow within the workplace, and relationships are strengthened. Not only does everyone work well together, but they actually enjoy working together. And when people enjoy working together, it's much easier for them to mentally cope with the stresses that come with their jobs. That means less burnout.

Trust can't be demanded. It comes from experience with another person over time and it is most likely to grow if someone believes that they are being dealt with fairly and honestly by another who genuinely wishes to help with a difficult situation. The Exchange helps create a climate of trust and respect.

Conflict is not about professional proficiency or training; it is about the reality of being human. People want to be treated fairly. They want to know they are respect-

ed, not only for their skills but also for their personhood. It's when those things don't happen – and when conflict is allowed to run rampant – that communication breaks down, collaboration is lost and case management to meet patients' needs suffers. And that's where The Exchange process comes in: It provides a way to communicate better, exchange respect and understanding, solve problems together, and facilitate better coordinated care for patients. CIP

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**Steven P. Dinkin,** along with **Barbara Filner** and **Lisa Maxwell**, are authors of *The Exchange Strategy for Managing Conflict in Healthcare: How to Defuse Emotions and Create Solutions When the Stakes Are High* and *The Exchange: A Bold and Proven Approach to Resolving Workplace Conflict*. Steven Dinkin is president of the National Conflict Resolution Center. Barbara Filner was the director of training for NCRC from 1984-2010 and currently works as a consultant for NCRC. Lisa Maxwell is currently the director of the training institute at NCRC. Web: www.exchangetraining.com

# Activating Healthcare Consumers Through Health Coaching

**BY WILLIAM K. APPELGATE, PHD**

Healthcare reform is changing the way we deliver healthcare in America. Whether you are an active part of one of the innovative CMS demonstrations or a commercially-centric initiative, or you are just beginning the journey toward medical home capabilities, you can appreciate the shift from volume to value.

Regardless of setting, the promise of delivering world class care management and care coordination should drive beneficial change in the care processes. You work passionately to create and sustain reduced admissions and ER visits and to limit avoidable readmissions. In addition, your day-to-day focus is on your patients – reducing the gaps in care, encouraging engagement,

and increasing personal accountability, thus improving their health outcomes, especially for those with chronic conditions.

Despite these efforts, significant obstacles stand in your way. In particular, our present system of patient education about both condition management and lifestyle decisions often leaves individuals confused and without the ability to follow through. Remember that 80-90 percent of healthcare occurs in the homes of individuals, and that is the healthcare that drives outcomes. As that frontline care professional, you understand implicitly that your potential for success does not stop when the patient leaves the facility. The breakthrough opportunity lies in being skilled and ready to engage individuals at the point of

care, and continues day after day in the lives of those you serve. This is the healthcare calculus that care managers can most effectively impact, and impactful health coaching skills should be part of that equation.

In this sense, the health coach is trained as a "care management facilitator" to take patients to higher levels of self-care and self-management. The health coach understands population health, the processes of stratifying a population, and administering proven interventions. More significantly, the health coach has developed a particular set of skills to partner with the individual, to elicit from the individual their own goals, and to become a "behavioral change specialist."

In these new models of healthcare, the

health coach can play a host of complementary roles. There is no one job description for a health coach but instead their adaptability is essential, and integrating those skills into the organization delivers two benefits. First, health coach skills enable the care team to transform the conversation with the patient and empower them to change the care processes to achieve the most effective outcome. Second, it provides adequate time to advance care management and coordination through direct interaction with targeted patients.

recent AHRQ study concluded that 95 percent of diabetes care in America is self-care. This statistic underscores the need to move from a system of simply educating individuals to involving individuals in their own care. Until patients are addressed as the decision-makers in their care and behaviors, their likelihood of being activated patients is lessened. The health coach respects and recognizes the individual as the owner of the strategies they will use to maintain or address their own health. An effective health coach uses evidence-

However, independent studies paint a somewhat different picture. They have found that: 1) 30-50 percent of patients leave their provider visits without understanding their treatment plan; 2) hospitalized patients retain only 10 percent of their discharge teaching instructions; and 3) chronically ill patients receive only 56 percent of clinically recommended healthcare.

Today's challenge is to create and foster patient-centered care coordination and care management that steps beyond education

## "THIS PROACTIVE APPROACH IS POWERFUL FOR ENGAGING INDIVIDUALS."

This health coach perspective complements and enhances the professional value and effectiveness for those at the point of care, now actively implemented in hundreds of clinics, community healthcare organizations and health systems nationwide. Here are some of the reasons that have driven their decisions to embrace the use of a health coach trained for the clinical setting.

**1. Improve clinical outcomes for those you serve.** The health coach is trained to use proven population health strategies to identify and invite individuals with chronic conditions to the office, the clinic or the healthcare center on a routine basis. This proactive approach is powerful for engaging individuals, and it is powerful in reducing the burden of chronic conditions which so frequently lead to hospitalizations and ED visits. Roughly 80 percent of healthcare cost is related to chronic conditions, and more than 80 percent of that cost comes from hospitalizations and ER visits. Given that a typical office visit costs approximately one percent of an inpatient hospitalization, any reasonable number of added physician office visits becomes an investment in reducing the cost of healthcare for the payer, the health plan, and now even the hospital. And the science supports this. Numerous research findings from the Agency for Healthcare Research and Quality (AHRQ), Mercy Clinics, California HealthCare Foundation and others support the efficacy of utilizing coaching strategies for individuals with chronic conditions – using coaching science in the clinical setting is a path to achieving improved outcomes.

**2. Engage and activate your patients.** A

based practices to assess the individual's readiness to change and even considers how the individual's communication style affects what they are hearing and understanding.

**3. Lead your organization toward the future of population health.** Achieving recognition as a patient-centered medical home can be overwhelming, and maintaining and improving the practice as a medical home will depend upon how well these systems produce superior results for patients, especially those with chronic diseases. Successful self-management strategies rely on engaged patients, and clinical health coaching addresses ways in which to engage patients.

For example, implementing an electronic health record can improve efficiency and support better care, but it cannot produce an engaged patient. It supports population health practices that address the needs of a panel of patients, whether fee-for-service or "capitated" risk. Organizations with the experience and the systems in place to meet the needs of a population of patients or members will be best positioned to form networks or accountable care organizations and practice successfully within them. Combining the health coach with technology, workflow and clarity of team responsibilities will enhance your overall medical home capacity.

**4. Improve the patient experience.** Healthcare providers have long sought to achieve high satisfaction among patients. Patients are often surveyed and queried as to how well they liked or how high they rated a particular visit, service or consultation. When asked by those providing the service, results reported are often good to excellent.

alone. Research has shown that coaching science outperforms traditional teaching for a broad range of behavioral problems and diseases. As healthcare professionals, your focus on measuring a variety of outcomes (including clinical, cost and patient satisfaction) will only increase. The real test, however, centers on the patient and driving their experience to a level of high value.

**5. Achieve financial success under any payment model.** Historically, it has been difficult for practices to implement strategies for unreimbursed services, such as care coordination, medication management, and tracking of patients with chronic conditions. No matter where you are in the continuum of payment models currently, health coach practices contribute to financial success.

Under "fully" or "partially" capitated payment models, or under shared savings arrangements, the benefits from better management of patients with chronic conditions produces savings in lowered hospitalizations and decreased complications. Under fee-for-service medicine, clinical health coaching acts as a business accelerator for the outpatient practice by producing an increased volume for evidence-based preventative exams and follow-up tests. This increased volume is more than offset in the total cost picture by the decreased utilization of expensive, typically inpatient services that can be avoided by regular and routine patient management.

### CONCLUSION

Healthcare professionals are routinely trained to do, teach and tell. Most are exceptionally

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## Agenda:

| | |
|---|---|
| 8:00 A.M. – 8:30 A.M. | Registration & Networking Breakfast |
| 8:30 A.M. – 9:15 A.M. | Introduction, Background and Definitions Related to Care Coordination |
| 9:15 A.M. – 10:00 A.M. | Professional Competencies for the Healthcare Workforce |
| 10:00 A.M. – 10:15 A.M. | Networking Break |
| 10:15 A.M. – 11:00 A.M. | Models of Care: New Opportunities for High-Quality Delivery |
| 11:00 A.M. – 11:45 A.M. | Communication Advances Enabling Care Coordination |
| 11:45 A.M. – 12:30 P.M. | Technology and Its Role in Care Coordination |
| 12:30 P.M. – 1:30 P.M. | Networking Lunch |
| 1:30 P.M. – 2:15 P.M. | Barriers to Care Coordination |
| 2:15 P.M. – 3:00 P.M. | The Consumer's Role in Care Coordination |
| 3:00 P.M. – 3:15 P.M. | Networking Break |
| 3:15 P.M. – 3:45 P.M. | Transitions of Care |
| 3:45 P.M. – 4:15 P.M. | Ethics of Healthcare |
| 4:15 P.M. – 5:00 P.M. | Behavioral Health: Where It Fits In |

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22432

# Making Sense of Motivational Interviewing: Delivering a New Understanding

BY BRUCE A. BERGER, PHD, AND WILLIAM A. VILLAUME, PHD

Motivational interviewing (MI) is the essential interactional foundation of patient-centered medical care. In order to facilitate constructive health behavior change by our patients we need to create rapport with our patients, explore how they are making sense of their situation, and then address their reasoning processes. Invoking an authoritarian stance and ordering patients to make major health behavior changes only creates resistance in patients. In contrast, MI invites patients to reexamine what health behavior changes they believe best serve their own personal goals.

This article summarizes the conceptualization of motivational interviewing as presented in the authors' new book, *Motivational Interviewing for Health Care Professionals: A Practical Approach*, which is to be published by the American Pharmacists Association Press in August 2013. We are indebted to the work of William Miller and Stephen Rollnick for describing and developing motivational interviewing. Their inspiring work has made disciples out of thousands of people, especially in the fields of addiction and substance abuse counseling.

In our book we have focused on explaining motivational interviewing in a way that is better adapted to healthcare professionals with little background in formal counseling and psychotherapy. Learning motivational interviewing in general can be challenging, but it is especially challenging to healthcare professionals (HCPs) for three reasons:

**1. Every day talk takes short cuts that often create problems when communicating with patients.** Every day conversations use words like, "OK" or "Uh huh" or "I understand" to try to communicate understanding and create rapport. Yet the other person may not really know what we mean or what it is we really understand. Here is an example.

*Patient:* The doctor just told me I'm HIV positive. He said this is what happens when you don't have safe sex.

*HCP:* Oh my.

The problem here is that we don't know what the "Oh my" means. Does it mean, "Oh my, you're HIV positive?" Does it mean, "Oh my, you didn't have safe sex?" Both of these potential meanings shame and blame the patient. If the HCP really wanted to communicate a deeper sense of empathy with the patient, then she needed to have said something like "Oh my, on top of the fact that you just found out you are HIV positive, the doctor shamed you about not having safe sex. All of this must be very difficult to take in all at once." MI requires that we be explicit in our communication and not

## "PATIENTS ARE EXPERTS."

take short cuts that can leave the meaning of what we say in doubt. In this example, even though the HCP wanted to be empathic and understanding, the abbreviated "Oh my" could easily have been misinterpreted and damaging to rapport.

**2. Healthcare professionals are often taught that they are "the expert."** As a result they often ignore the expertise of patients and wind up judging and lecturing their patients. In contrast, MI is a meeting of two experts who exchange their respective expertise. Patients are experts about 1) their understanding of their disease state and its treatment, 2) their goals in life, and 3) what they believe they can do.

HCPs cannot use their expertise effectively until they have assessed these three things. For example, when patients are asked to talk about their understanding of what high blood pressure means to them, one patient may say, "Well, I know it can be very serious. If my blood pressure stays up I can have a stroke or heart attack and I don't want that to happen." Another patient may say, "I don't know much about it. I feel fine, so I don't know what the big deal is." The first patient is ready to treat his high blood pressure and can be given options to do so. The second patient is not ready for treatment options. She needs to understand the risks of not treating her blood pressure. Then she needs to make sense of how she can feel

fine and still be at high risk. Without tapping into each patient's "expertise," the HCP might treat both patients the same way and thereby lose influence on the patient most likely to be nonadherent to treatment.

**3. Introspection is a significant part of the training of psychologists who treat patients.** It is generally not a part of HCP training. To be effective at MI, HCPs need to learn to be introspective and reflect on how their own needs and anxiety often causes them to try to "fix" or persuade patients who are not ready to engage in various health behaviors. For example, when a patient expresses resistance, HCPs often become anxious. Rather than recognize that the patient is making a commitment to taking the medicine, they may say, "That's not enough. You also need to eat healthier and get more exercise." They fail to recognize the commitment and end up scolding the patient. This simply causes more defensiveness.

Motivational interviewing has traditionally been taught as a series of tools or skills often summarized in the form of acronyms such as "READS" or "OARS." Trained counselors can usually sense the import of these skills and integrate them into their foundational understanding of the psychotherapy process. In contrast, HCPs are often confused by these acronyms. All too often they wind up asking "How am I supposed to know which tool to use at what point in the process?" In our forthcoming book we explain MI in terms of facilitating the patient's sense making. The choice of which MI tools to use is naturally guided by how our patients are making sense of 1) their health situation and 2) their relationship with us.

Our explanation of MI emphasizes that human beings are sense-making creatures. We try to make sense of things. We say, "That makes sense" or "That doesn't make sense." Patients attempt to make sense of two fundamentally important things in healthcare:

**1. Their illness and/or treatment.** For example, when patients find out they have high blood pressure they formulate what

this means to them. In other words, they make sense out of it. In the earlier example, one patient's sense was that high blood pressure was serious and had serious risks if left untreated. The other patient's sense was that if she felt fine then high blood pressure was no big deal. The second patient was really saying, "If I feel fine, I am fine." Our task in using MI is to address the patient's sense making in a caring, nonjudgmental and respectful manner. In the second example, any information we provide must address the question implied by the patient, "How can I feel fine and still be at risk?"

**2. The relationship.** Patients are also making sense of the relationship with the HCP. Is the HCP caring, kind and respectful of me or is the HCP judgmental, paternalistic and treating me like a child? If the patient says, "I don't know much about high blood pressure. I feel fine, so I don't know what the big deal is" and the HCP responds, "Just because you feel fine does *not* mean you are fine. Your blood pressure is elevated. You don't want to have a stroke or heart attack, do you? You need to take you medicine," the patient will likely perceive the HCP as judgmental and scolding.

Even though the information provided may be accurate, the patient can easily ignore or discount it because the patient's sense about the relationship is "I don't trust this HCP."

Using MI, we would build rapport with the patient so that the patient is willing to trust any information we might share in order to address the patient's reasoning as is illustrated in the following dialogue:

*Patient:* I don't know much about it. I feel fine, so I don't know what the big deal is.

*HCP:* So, because you feel OK, you're wondering whether you really need to do anything about your blood pressure.

*Patient:* Right.

*HCP:* You raise a great question. Would you mind if I told you some things about your blood pressure and you tell me what you think?

*Patient:* That would be OK.

*HCP:* Unfortunately, high blood pressure is a condition that usually does not have any symptoms you would notice. The first symptom is usually a stroke or heart attack. Your blood pressure is elevated. That puts you at risk of stroke and heart attack. The

medicine can lower your blood pressure and lower your risks substantially. What are your thoughts now about taking the medicine and taking other steps to greatly reduce your risk or stroke and heart attack?

Notice here that the patient's sense making is reflected back in a caring and respectful manner in order to build rapport. Permission is asked to provide new information for the patient to consider. After the information is provided, the HCP asks about the impact of this new information on the patient's sense making. In MI the patient is invited to consider how the new information may call for the patient to rethink how she views her illness and what she thinks she needs to do.

## RAPPORT, IMPORTANCE AND CONFIDENCE

Finally, as we are exploring a patient's sense making about his illness, we are listening for issues of importance and confidence. That is, how important is it for the patient to treat the illness or change a behavior(s) and how confident is the patient he can make the necessary changes? Importance and confidence are critical to motivation for change. If the patient does not believe that the illness is serious or does not believe that the treatment is effective, the patient is unlikely to implement any behavior change.

Again, using our example, because the second patient felt fine, she did not understand the importance of treating her high blood pressure. Hence, her motivation to do so was low. In the MI response to her, the healthcare professional first built rapport by respectfully reflecting back the patient's sense making. Rapport is critical. It creates the leverage needed for the patient to hear the expertise of the HCP as being an extension of caring. It allows the patient to sense that the relationship is beneficial to her. After building rapport, information is provided to assist the patient in sensing the importance of treating her high blood pressure – even though she feels fine.

In addition to importance, we also listen for confidence. Many patients sense the importance of engaging in behavior change, but lack the confidence to do so. This is not uncommon in maintaining weight loss, smoking cessation and engaging in a new behavior (e.g. injecting insulin). We want to develop rapport by

explicitly empathizing with the issue making them less confident about implementing health behavior change, and then by offering to help the patient gain the confidence necessary to engage in behavior change.

## SUMMARY

We have outlined our new conceptualization of how motivational interviewing works by facilitating the patient's sense making. That involves:

1. Respectfully listening for how patients make sense of their illness and treatment (importance or confidence) and explicitly reflecting back our understanding in a way that allows them to know we care about them and understand their perspectives.
2. Asking permission to address their issues and concerns (sense making).
3. Providing focused new information to consider.
4. Asking how this new information affects their decision making.

When we do these things we have the opportunity to assist our patients in reasoning their own way to the need for constructive health behavior change. Ultimately, when MI builds rapport with the patient in order to address the patient's sense making, MI achieves a tremendous synergistic impact that significantly improves patient outcomes. CIP

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# A New Model of Understanding the Self, for Improved Wellness and Control

**BY MARGARET MOORE AND TERESA TREIGER, RN-BC, MA, CHCQM-CM, CCM**

Perhaps you have encountered this phenomenon of the human mind: you notice an inner dialogue among your inner voices, who don't always agree on the best decision or the way forward, creating ambivalence or even a sense of "stuckness." When faced with the choice of an apple or a brownie, a self-regulating voice may remind you of your goals to be healthy and manage weight. Then another voice insists on the pleasure of the brownie to make this moment more pleasurable.

What if there was a better approach to leading one's inner team, to respect and appreciate all of the inner voices, and soothe the ones who are suffering so they don't sabotage your best intentions? This article features a self-coaching model based upon a just-published hypothesis titled: *Coaching the Multiplicity of Mind: A Strengths-based Model* (Moore, 2013).

The new model builds upon Internal Family Systems (IFS) therapy, developed by psychologist Richard Schwartz over the past 25 years. One of Schwartz's empirical discoveries is the concept of a central mindful "self" that is able to observe and accept our inner voices with acceptance and without judgment.

## EXPLORING THE DEPTHS OF SELF

IFS therapists help people access the mindful self and invite their voices, called "parts," which are experiencing negative emotions to a mindful, meditation-like sit-down. The "parts" appear to manifest as a construct that psychologists call sub-personalities, each with distinct needs, agendas, emotions, narratives and perspectives.

The therapy session follows a winding trail to uncover small or large traumas of the parts and then unpack their interesting and often surprising stories. The client sits compassionately with the suffering of the parts, and experiences a process designed to appreciate and accept, then heal and release the burdens of parts.

The new model proposes that a set of primary capacities, or sub-personalities, form a strengths-based structure of the inner family. Figure 1 lists a set of primary capacities. The two authors of this article, a coach (Coach Meg) and a case manager (Teri), explore an inner family dynamic as it relates to a case manager's self-care trajectory and applying the model of primary capacities.

*Coach Meg:* Teri, your inner family dynamic has changed dramatically over the past year as health moved to the top of your priority list and you transformed your health habits, losing 80 pounds slowly and steadily. What were the big shifts?

*Teri:* I realized first that I was living with an often-nasty inner critic, my standard-setter, which has always demanded a high bar in terms of accomplishments. While this voice served me well in my career, it routinely told me that "I was not good enough" when it came to my weight and health. This bruised my confidence, which worried constantly that I would never be successful in losing weight, or content with each moment along the journey. It would often give up, and allow deeply-wired impulses to hijack my behavior and reach for unhealthy foods to make me feel better. Then the standard-setter would beat up on my confidence for failing, rarely forgiving or cutting some slack, creating a vicious cycle of criticism, overeating, anger and defeat. The voice of my body regulator, who knew what was optimal for my health, often was drowned out by the angry and defeated voices. It felt neglected and sad.

*Coach Meg:* That was a tough place to be, having three members of your inner team stuck in distress. What were some pivotal moments that allowed you to break out of the stuckness?

*Teri:* I was lost in this inner chaos, except while I was working, when my well-organized executive manager harnessed my creative to do good work. I used my work to escape from the chaos. The whisper of a wake-up came when you suggested that I read Dick Schwartz's book on his model of the internal family system. I first realized that I was not accessing my mindful "self" as an objective, nonjudgmental, and accepting observer, allowing me to appreciate both the good intentions and the frustration of each team member. I was then able to notice my standard-setter's inner criticism and its anger, and my confidence's yearning for a realistic standard and its feelings of defeat. I acknowledged and appreciated their intentions, and learned to give them self-compassion, often crossing both hands over my heart as I sat with their negative emotions, rather than ignoring them or trying to talk them out of their states. This was not easy.

*Coach Meg:* It never ceases to amaze me how compassionate nurses can be toward others, and how difficult it can be to empathize with one's own suffering, which is simply signaling unmet needs. We can then decode the messages of our negative emotions and take steps to meet unmet needs. What happened next?

*Teri:* I began to ask my standard-setter to lower the bar, which energized my confidence. If they regressed to the old pattern, I would show appreciation and compassion again, and ask them to step aside rather than hijack me. Then I could really tune into my body regulator, who was surprisingly clear on what choices to make about eating and exercise. It took many months of practice before I could readily lower the bar or set aside the old strife, and just be with my body's needs for good nutrition, daily walks, and healthy sleep.

As my physical well-being improved, my adventurer was awakened and I began to be more curious about my journey, summoning an energetic sense of wonder about the possibilities ahead. Perhaps the biggest shift was tuning into my "spirit" part, what you call the meaning maker. It formed a bridge from my past mindset of struggle to a new one with more balance and equanimity. It taught me to accept myself more and more fully, using a biology metaphor: every cell is doing the best it can with the resources it has available. Basically I am simply at my best in every moment, all parts of me doing the

**Figure 1**

| Proposed Primary Capacities That May Function as Sub-personalities | |
|---|---|
| Self (leader) | To listen, see the truth, integrate all capacities into a whole |
| Autonomy | To be free and independent, to do what one wants to do |
| Body Regulator | To get to balance, equilibrium, calm, and good health |
| Confidence | To be strong, competent, and confident |
| Creative | To be creative, spontaneous, and have fun |
| Executive Manager | To be organized, do things well, and figure things out |
| New Experience Seeker | To seek new experiences and change |
| Meaning-Maker | To connect the dots, see the big picture, and create harmony |
| Relational | To love and serve others |
| Standard-Setter | To set the bar, achieve goals, and get approval and recognition |

best they can, even if that seems below my standard-setter's standard. This is not a new idea of course; however embodying it has been one of my life's greatest lessons.

*Coach Meg:* It's interesting how the true nature of the journey wasn't about weight loss, but leading the inner team in a new way: listening, understanding and appreciating. As more unmet needs got met, you had access to more of your whole self, which added new resources and energy. Say more about that.

*Teri:* Like a jazz ensemble I became much more aware and conscious of all of my resources. For example, my autonomy is strong, which enabled me to be self-sufficient from a young age. It helped me find my own compass and not overrely on others' opinions, which are plentiful when it comes to weight loss approaches. My relational is blessed with empathy skills; in fact, I recognized that I got lost in other people's

pain and neglected my own. I rely on my relational daily for self-forgiveness and self-compassion and it doesn't let me down. I love my creative, and I've organized my work projects so that I can express my creativity most days, which is a joyful energy that recharges my batteries.

*Coach Meg:* You are beginning to experience and enjoy a new level of energy and harmony, a wonderful gift along with new physical health and strength. What are the themes of the next chapter of your story?

*Teri:* I journal several days a week, a kind of roll call of my inner team. They are my friends and teachers and they still often surprise me. Now that my confidence has a stronger belief in my abilities, my adventurer is urging me to take some bigger leaps in my professional life, which is exciting. My body regulator is getting more ambitious and I have started training for a walking race. My

standard-setter and executive manager are still prone to push too hard. I can usually ease the tension by showing them gratitude and appreciation for all that they do, and suggesting that they could relax more as there are now other parts of me sharing the load. Perhaps the biggest discovery is that my weight loss journey is not really about losing weight, but becoming whole, healthy and happy. Now that's cool. CIP

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# Class In Session: Creating Long-Lasting Wellness Among Children

BY JESSICA FRIEDMAN, MPH

In the United States, childhood obesity has more than doubled in the last 30 years, increasing the risk factors for cardiovascular disease, type 2 diabetes, several types of cancer, and osteoarthritis.

The organization that I work for, the Institute for America's Health, is a nonprofit that works to address these problems with the mission to inspire, motivate and educate youth to make healthy lifestyle choices. By employing a whole-child approach, we have created a nationwide health initiative that addresses all areas of a child's growth and development in order to empower and excite youth to start making healthy choices beginning at a young age.

It is our goal that through child empowerment these ideas will be brought home to families and spread throughout communities to create sustainable and lasting change.

## SHAPING A BETTER WAY

The WAY (Wellness, Academics, and You) to a Healthier America Model School Initiative is the Institute's platform to address these health issues and to inspire youth to begin making healthy life choices. Through a generous grant from the Walmart Foundation, we have been able to provide partner schools with free standards-based resource guides that are wellness and nutrition-themed, materials, supplies, teacher training, and continuous coordinator support for the last two years in Chicago, Washington, D.C., and Atlanta.

This is a classroom-based initiative that continually exposes students to themes of health, wellness, hygiene, physical activity and messages of positive self-esteem while adhering to required state standards in language arts, math, science, physical education and health. By initially training teachers, we hope to motivate them to use the materials and WAY lessons in their daily plans and also to change the culture of their classroom to one of a healthy and safe space for all of their students.

A fourth grade teacher I work with in Washington, D.C., used to decorate her classroom bulletin board with wrappers and menus from neighborhood fast-food restaurants as part of a lesson on using currency. The consequence of this theme was that her students were constantly thinking about the unhealthy food served at these restaurants and could often be found at these establishments immediately after school was dismissed. After beginning to implement the lessons and themes used in the WAY program, this teacher started changing the culture of her classroom and took these unhealthy reminders off her wall. Instead, she put up posters encouraging students to eat fruits and vegetables and even had students create their own healthy-themed posters with their own slogans as positive reinforcements. She has reported that her students are more excited about making healthy choices and that fruit and vegetable consumption in her classroom for in-school breakfast, lunch and snack-time has increased.

Besides nutrition and physical activity, we constantly work on character development with the students using WAY. A theme that is woven throughout all of the kindergarten through fifth grade curriculum guides is "I Am The Greatest," which reinforces the notion that as long as one tries their hardest, they can be the best version of themselves. We encourage teachers not only to put up healthy posters such as My Plate and the Food Pyramid, but also positive messages such as these to bolster ideas of empowerment for the students. In fact, one of the schools I work with in Washington, D.C., used the "I Am The Greatest" lesson as their theme for graduation, with each elementary school graduate reciting what they did that year to make them the greatest version of themselves.

These are the primary changes that we at the Institute for America's Health hope to initiate, as small behavior changes can be like the proverbial stone thrown into the pond: the ripple effects are endless. In 2004, Dr. David Katz of the Yale School of Public Health evaluated the WAY program for the CDC. It was found that the WAY program is directly correlated to a statistically significant reduc-tion in BMI in students who used the program in comparison to students at the same school who did not. Additionally, other positive changes were documented, such as increased consumption of healthy food choices, higher physical activity levels at school and at home, higher test scores and academic performance, decreased truancy rates and rates of disruptive behavior, and improved goal-setting skills and feelings of personal accomplishment. Additionally, it was found that the families of students using WAY showed increased physical activity levels, improved nutrition and eating choices, enhanced communication, and less sedentary activities.

However, creating change in the nutrition and lifestyle choices of the students we work with does not end in the classroom. We advocate the Coordinated School Approach, in which the entire school is brought on board. While the fundamentals of the WAY lessons and activities are implemented in the classroom setting, resource teachers, nurses, cafeteria managers, PE faculty, counselors, and all others who play a role in schools are encouraged to attend workshops and use their resources to apply WAY to their professional settings. This builds a true sense of community within the school, with everyone working toward a common, healthier goal.

Additionally, program coordinators (like me) work with the school to create change within the neighborhood or community that a school is located in and to bring as many opportunities and resources to that community as possible. Since many of the schools that are part of the initiative are in traditionally underserved neighborhoods and food deserts, it has been important not only to provide health education, but to bring as many resources to the communities as possible. We have found that while many children are in the obese-range, many other children that are of average weight suffer from types of malnutrition from lack of access to healthy, fresh food and from overeating heavily processed packaged foods.

We believe that it is not fair to tell a child

that they need five servings of fresh fruits and vegetables per day without giving them access to such foods. Our grant from the Walmart Foundation has allowed us to fund schoolwide health projects and to bring such resources and access to each of our model schools in order to create hands-on learning experiences for students, teachers and community members. Projects in the past have included building school gardens, classroom Earthboxes, field trips to urban farms, and healthy snack days. We also partner with other organizations to create more opportunities for our partner schools; whether it be a before- or after-school Zumba class, cooking lessons using food grown in the school garden, or working with parent advocacy groups to get parents involved in the nutrition choices at school, the limitations are endless. In the end, our goal is to get each school community able to reach their health and wellness goals, to be self-sufficient, and for their projects to be sustainable.

According to the Robert Wood Johnson Foundation's report "F as in Fat," the obesity epidemic is having a major impact on the health of school-aged children, since one-third of all children are classified as obese. If this health trend isn't reversed, the current generation of young people could be the first in U.S. history to live sicker and die younger than their parents' generation. A message that we stress in our WAY workshops is that a teacher, an administrator, or a coordinator cannot do everything, but we can do something.

By initiating little changes in the classroom, we can alter lives and change the path originally travelled. By reinforcing positive messages and encouraging students to start making healthy choices for themselves at an early age, we can inspire that child to live a healthier life and become a healthy, productive adult. As a coordinator, I have seen these changes occur in less than a school-year, with students making healthy choices like eating foods from all five food groups, saying no to

chips and soda and yes to carrots and water, and taking extra time in making sure to wash their hands. While these are small changes, they are changes in the right direction. CIP

### RESOURCES

1. Robert Wood Johnson Foundation, "F as in Fat: How Obesity Threatens America's Future," 2012.
2. Centers for Disease Control and Prevention, "Adolescent and School Health: Childhood Obesity Facts," February 19, 2013.

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# A State of Decay? A Clarion Call to Advance Oral Health in America

**BY LT HYEWON LEE AND DENTAL PROFESSIONAL ADVISORY COMMITTEE OF U.S. PUBLIC HEALTH SERVICE**

*Disclaimer: The contents are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Public Health Service or the Department of Health and Human Services.*

In healthcare and healthcare policy, oral health is often excluded from overall health. Mounting evidence shows that oral health, an integral part of overall health, affects people's well-being. However, oral health historically has been separated from general health in various aspects. Differences in curricula and training modules between medicine and dentistry, separate insurance systems, lack of interoperability between medical and dental records, and a divided care delivery system are examples.[1]

"Dentistry" is a more common term than "oral health," but oral health will be used in this article to describe comprehensive health of the oral cavity. Oral health status in the U.S. will be examined along with the inter-relationship between oral health and overall health and current efforts to integrate oral health and primary healthcare.

## ORAL HEALTH IN AMERICA

In 2000, the U.S. Surgeon General report brought attention to a "silent epidemic" of oral disease in the nation.[2] Dental caries (tooth decay) is the single most common chronic disease among children ages 5 to 17, occurring five times as frequently as asthma in the U.S.[2] Nearly one in five children aged 6-9 years have untreated dental caries and oral health disparity is even more prominent among children from minority populations and low-income families.[3] Among adults aged 45-64, more than 70 percent do not have a full set of permanent teeth and more than one in five elderly aged 75 and over have no natural teeth.[3] In addition, 47 percent of adults in the nation aged 20-64 and 70 percent of older adults aged 65 and older suffer from periodontitis (gum disease).[4]

In 2012, it is estimated that more than 40,000 people will be diagnosed with cancer of the oral cavity and pharynx and nearly 8,000 will lose their lives due to such cancers.[5] The overall incidence of head and neck cancers is steadily decreasing, but the incidence of oropharyngeal cancers in the U. S. has increased between 1973 and 2007, and the number of younger women diagnosed with oral cancer without the common risk factors such as tobacco and alcohol is increasing.[6,7] Recent studies show that about one in four head and neck cancers is associated with human papillomavirus infection.[8,9]

## BRIDGING ORAL HEALTH AND OVERALL HEALTH

Along with the significant oral health burden in the U.S., there is growing evidence of bi-directional impacts of oral health complications and other systemic diseases. Periodontal disease is an oral infection caused by pathogenic bacteria that trigger chronic inflammation and destruct structures that support the teeth.[10,11] According to the National Center for Chronic Disease Prevention and Health Promotion (2011), adults ages 45 years or older with poorly controlled diabetes (HbA1c greater than 9 percent) were 2.9 times more likely to have severe periodontitis than those without diabetes due to hyperinflammatory responses and slower wound healing.[12,13] On the other hand, unmanaged periodontitis has been reported to adversely affect glycemic control in patients with diabetes,[14] and periodontal therapy was associated with improved blood glucose levels.[15,16]

Studies showed that besides diabetes, poor oral health and the inflammatory nature of periodontal disease are associated with increased bacterial systemic exposure and may be associated with cardiovascular disease, including endocarditis[17,18] and respiratory disease.[19] The American Heart Association (AHA) recommends infective endocarditis prophylaxis for dental procedures for patients with underlying cardiac conditions associated with the highest risk of adverse outcome from infective endocarditis.[20] The AHA also issued a statement noting that although the available data do not support a causal relationship, observational studies support an association between periodontal disease and atherosclerotic vascular disease independent of known confounders.[21] Additionally, oral diseases and poor oral hygiene can induce pulmonary infections, especially nosocomial pneumonia in high-risk individuals, such as mechanically-ventilated hospital patients. Improved oral health hygiene can prevent such episodes.[19]

The mouth can serve as a place to detect signs of general health problems.[2] Oral lesions are common manifestations of nutritional deficiencies, HIV infections and other certain diseases. Early detection of these diseases through a thorough oral health exam can increase health outcomes and quality of life of individuals. Dry mouth (xerostomia) is an early symptom of autoimmune disorders. Dry mouth is also a side effect of various medications, especially among elderly populations.[22] Medications that can cause dry mouth include antihypertensives (to lower blood pressure), antidepressants, diuretics and antihistamines. Individuals taking medications that cause dry mouth and healthcare professionals prescribing them should be aware that they may increase the risk for dental caries.

## ORAL HEALTH AND SOCIETY

It is not just physical health, but also psychological, social and economic health and well-being that are affected by oral health complications. It is estimated that 164 million hours of work and more than 51 million school hours were missed due to dental related illnesses.[23] In 2008, more than $100 billion was spent in the United States for dental care, and $30.7 billion was paid out-of-pocket. Out-of-pocket expenses for dental services were the second highest of all out-of-pocket healthcare spending.[24] In Florida, there had been more than 115,000 hospital emergency department (ED) visits for dental problems, which cost $88 million,[25] and the rate of ED visits due to dental-related issues exceeds the rate of visits for both asthma and diabetes in many parts of California.[26]

Consequences of poor oral health may negatively influence children's speech, nutrition, growth and function, and social development.[2] Studies show that students with poor dental health were nearly three times more likely than their healthy peers to miss school due to dental pain, which is also related to weaker academic performance.[27,28]

## INTEGRATING ORAL HEALTH AND PRIMARY CARE

Recognizing oral health as an integral part of overall health, both public and private healthcare entities have increased their efforts to integrate oral health into primary healthcare in various aspects. In the summer of 2012, the Ad Council launched a national oral health campaign in collaboration with the American Dental Association to increase awareness of children's oral health. In 2010, the Department of Health and Human Services (HHS) announced the HHS Oral Health Initiative, which has resulted in a number of advances, including two landmark oral health reports published in 2011 by the Institute of Medicine (IOM). These reports provided recommendations to advance oral health in the nation for all stakeholders in the healthcare system.[1,29]

Nondental primary care professional organizations increased their interest and support for the integration of oral health into primary healthcare both at the educational level as well as practice level through development of interprofessional collaborative practice curriculua, oral health training modules for nondental healthcare providers, and projects and research studies with different integration models.[30,31,32] Most states in the U.S. currently reimburse for preventive oral health services performed by primary care providers,[33] and children who are eligible for Medicaid and Children's Health Insurance Program (CHIP) can receive comprehensive dental coverage through the CHIP Reauthorization Act.[34] Recently, an increasing number of research studies on socioeconomic factors that influence oral health and oral healthcare were conducted to examine deeper causes of the current oral health disparity.[35,36]

## ORAL HEALTH LITERACY

Oral health literacy is defined as "the degree to which individuals have the capacity to obtain, process and understand basic oral and craniofacial health information and services needed to make appropriate health decisions."[37,38] Individuals and families can help determine their health and wellness, including oral health. True changes in healthy behavior are influenced by an individual's value placed on health status, and not merely from accessibility or affordability for care. Health professionals play a major role in advancing health literacy and should employ techniques to assure patient understanding, such as those found in the Health Literacy Universal Precautions Toolkit.[39]

Low economic status and a limited level of education are important determinants of oral health diseases including dental caries, periodontal disease and oral cancer. Oral health disparities are more prominent among racial ethnic minority groups and older adults,[40,41,42,43] and these are the populations with low levels of health literacy.[44,45,46] Studies show that limited health literacy is associated with fewer dental visits and a lack of knowledge about preventive oral health interventions, including community water fluoridation.[40,47]

The Institute of Medicine's oral health literacy roundtable[40] and other recent efforts examining oral health literacy are promising steps in empowering populations to understand and appreciate the value of oral health and achieve optimal oral health. Through future oral health literacy research studies and programs, we can expect to learn the lessons that health literacy literature brought into medical communities. Furthermore, efforts to increase oral health literacy among nondental primary care health professionals are essential in raising awareness of oral health diseases and promoting the importance of good oral health in relation to general health and well-being.

## CONCLUSION

There is much work to be done to advance oral health in the nation, especially for vulnerable and underserved populations. The starting point in advancing oral health is the development of a sound oral healthcare delivery system that provides high-quality care. The time is prime for health policymakers to create a platform for affordable and accessible oral healthcare that can exchange meaningful data with existing medical care systems. Sustainable health policies can inform and address oral health workforce development and oral health workforce distribution in dental health professional shortage areas.

A future oral healthcare delivery system must support interprofessional collaboration and oral health promotion among all healthcare providers. Some people say the chasm between dentistry and medicine will not disappear completely and others say current initiatives and high-level interests in integrating oral health into overall health is just a "window" of opportunity. However, small changes in primary care practice and dental practice can make significant and lasting differences for the populations served. If primary care physicians examine the mouth before they check the patient's throat, this is an immediate opportunity for timely integration of care. If dental providers measure blood pressure, test or refer patients for glycemic control, counsel against tobacco use and ask thoughtful questions related to general health and well-being of their patients, sustainable interprofessional collaboration is possible. If dental and nondental healthcare providers learn how to collaborate to achieve the best health outcome for the patient, this presents opportunities to improve the nation's oral health status.

By recognizing oral health as an integral part of overall health and emphasizing oral health issues as health problems, we will be able to lessen the impacts of the current oral disease epidemic and secure future oral health parity in the nation. CIP

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# A Fresh Look: Exploring the Varied Health Benefits of Massage Therapy

BY JILL LONG, MBA, ATC, CMT

Massage therapy, once considered by many to be a luxury, is gaining wider acceptance in the medical community. In 2011, the American Massage Therapy Association reported that 18 percent of Americans reported having had at least one massage in the previous year. Of those who received massage, 44 percent received massage for medical or health reasons, up from 35 percent the previous year.

Medical professionals, particularly physicians, chiropractors and physical therapists, are increasingly recommending massage therapy for their patients. Some insurance companies will even cover massage therapy as a treatment if prescribed by a physician. This shift is reflective of the increasing tendency of Americans to be taking a proactive, rather than reactive approach to healthcare.

## ASSAYING THE APPLICATIONS

Massage is widely defined as the manipulation of soft tissue, including skin, muscles and fascia. Massage has applications in both treatment and prevention of a variety of injuries and illnesses. While massage by itself is not a cure-all, it can be effective in relieving pain and decreasing stress. Massage can be used in conjunction with both traditional Western medicine as well as other complementary and alternative therapies, such as chiropractic and acupuncture.

Some of the most common injuries and ailments treated by massage therapists include repetitive strain injuries like carpal tunnel and thoracic outlet syndromes, as well as chronic neck and back pain. Massage therapy treatment in carpal tunnel syndrome and thoracic outlet syndrome typically includes multiple components. It is critical to address the musculature of the neck, shoulder, chest and arm; specifically the scalenes, pectorals, and forearm flexors and extensors, with both massage and passive range of motion. These conditions are often caused by chronically tight, hypertonic muscles impinging on nerve pathways.

Massage can loosen the offending muscu-

> ## "MASSAGE CAN ALTER LEVELS OF HORMONES AND NEUROTRANSMITTERS."

lature, thereby diminishing discomfort. A common cause of chronic neck and back pain is the presence of trigger points, which are hyperirritable bands of tissue formed by repetitive movements and strain. Pain reduction can occur with treatment of these trigger points in the immediate and surrounding areas. An important consideration with most chronic pain conditions is to address workplace ergonomics. Massage will have limited, shorter term effectiveness if the client returns immediately to the poor posture and habits that initially caused the problem.

Massage is also a useful tool in postoperative rehabilitation, particularly in combination with physical therapy. One of the best-publicized benefits of massage is its ability to improve circulation. Increased blood flow to the soft tissue affected by surgery can reduce healing time. Loosening the involved and surrounding musculature can decrease pain, increase range of motion, and facilitate strengthening. Massage can also help break up scar tissue, allowing it to realign in a less constrictive pattern. Manual lymphatic drainage, a subtle form of bodywork, is useful in rerouting stagnant lymph after such surgeries as mastectomy and open heart surgery.

Massage therapy is also frequently used to treat people who suffer from such maladies as fibromyalgia and migraine, as well as depression and anxiety. Massage for these and other chronic physical and psychological conditions can decrease physical and emotional pain and stress levels, as well as improve sleep quality. Massage may also bring awareness to the way "seemingly disconnected postural and movement patterns can create pain in an entirely different area of the body" (Werner, 320). All of these benefits may serve to improve the client's overall quality of life. With psychological disorders in particular, massage to promote relaxation and stress reduction can

be a useful adjunct to existing pharmacological and psychotherapeutic treatments.

## ENUMERATING THE BENEFITS

Recent research suggests a frequent cause or contributing factor in disease is stress. Between 60 and 80 percent of patients seen by their primary care doctors are determined to have a stress-related component to their disease. High levels of stress, whether eustress or distress, can be linked to various physical and psychological conditions. One of the most noteworthy benefits of massage is relaxation. While this benefit may be construed by some as evidence that massage is strictly an indulgence, such is not the case. Massage facilitates the body's shift from a sympathetic to a parasympathetic state.

The sympathetic state, also known as the "fight-or-flight" stage, is the condition in which many of us spend our waking hours. This state is characterized by elevated blood pressure, heart rate and respiratory rate. The parasympathetic state, on the other hand, allows rest, restoration and return to homeostasis. Spending more time in a parasympathetic state can lower blood pressure and heart rate and improve digestion and elimination.

Massage can alter levels of hormones and neurotransmitters, including decreasing cortisol and substance P levels and boosting serotonin and dopamine levels. Additional benefits of massage include improved circulation of blood and lymph, increased range of motion and flexibility, enhanced health of the skin, and better functioning of the immune system.

## COVERING CONTRAINDICATIONS

While massage has many wonderful benefits, there are some important cautions and contraindications to consider. Absolute contraindications exist in which massage may exacerbate the condition or cause harm. These include systemic infection, acute or unstable conditions or injuries, active flare of autoimmune disorder, and fever.

With local contraindications, massage may still be performed elsewhere in the body.

Examples include open wounds, unhealed fractures, varicose veins, localized – whether contagious or not – and recent surgery. Other cautions include cancer, pregnancy, diabetes and heart disease; massage may be safe for individuals with these conditions, but recipients are encouraged to consult with their physician prior to receiving massage. Because there are a variety of different approaches to massage, it is also suggested that massage recipients ask their massage therapist questions about their training and experience to further optimize results.

## CONCLUSION

The lack of adequate, positive touch has far-reaching effects on the psychological, emotional and physical aspects of health. Studies about touch in general indicate the connection between life and touch. One study from the 1920s showed that infants who were abandoned at birth and sent to orphanages wasted away in spite of being fed and kept clean and safe. The death rate of these infants, under the age of one, was nearly 100 percent, indicating the basic need for physical contact. As this need was realized, healthcare providers changed their approach, holding, stroking and talking to the infants in their care. There were instant results, with mortality dropping within a year's time.

Massage should be considered an investment in one's health as opposed to merely an extravagance. Massage also can be used as a preventive measure, either to stave off disease or to prevent existing conditions from worsening. The human body has an incredible ability to heal itself with little or no outside intervention. Massage supports that healing through the support of body systems, as cited above, as well as providing the positive, physical touch we need to be our best selves. CIP

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worker manage through this life transition.

The research outlined in this article shows that wellness can be an important factor in improving productivity, and that older workers recognize the benefits of wellness. In approaching the challenge of motivating the older worker, it is important to recognize psychosocial issues that affect these employees. In many cases, they may be less technologically savvy than younger workers, tend to be a cultural minority, perceive biases against older workers, be conflicted about change or feel out of step in an intergenerational workforce.

In conclusion, unhealthy workers negatively affect employers through increased healthcare costs and decreased productivity. A lifetime of poor choices leads to health risks and chronic conditions that negatively impact the health and productivity of aging workers. Worksite-based health promotion can be used to stabilize and bend the trend, favorably impacting productivity, healthcare costs and employee retention. There are distinct differences between age classes of the employees that must be acknowledged and embraced in order for such programs to be effective.

Understanding the health-related realities of generational diversity can create a more vibrant workforce and, ultimately, a competitive advantage for employers. CIP

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talented in this approach to delivering healthcare. But a challenge exists – namely, getting the patient activated. By virtue of training combined with clinical expertise and experience, the health coach is able to partner with patients to activate positive health behaviors that support self-management, self-care and the reclaiming of responsibility for one's health.

The most important challenge in healthcare today is activating patients to be drivers of their own health futures. Because when it's all said and done, achieving this level of self-direction, self-determination and personal responsibility, guided by the health coach in various roles and throughout the care process, is the ultimate goal of real healthcare reform. CIP

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