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Case Management ADVISOR™

Covering Case Management Across The Entire Care Continuum

INSIDE

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Workers' compensation/managed care

Poor workers' comp loss ratios offer opportunities for forward-looking CMs

How to grab your share of the market

It's time for case managers to mount their white horses and charge to the rescue of a workers' compensation market that can no longer offset poor loss ratios with investment income. As that market continues to harden, payers and self-insured employers will continue to demand the type of effective management approaches to lost-time occupational and nonoccupational claims that case managers are best-suited to deliver, say market observers.

"This is a great time for case managers to go to employers and say, 'I want to work with you on improving your productivity.'"

"Until recently, workers' comp premiums have been depressed — the workers' comp market has been cheap for the past five years. Employers weren't that anxious to lower their costs, but that's taken a turn, and rates are going back up quickly," says **William L. Granahan**, CIC, LIA, CMC, a senior consultant and practice manager with Milliman & Robertson's Boston office and co-author of the recently released report "Fifth Annual Milliman & Robertson Survey of HMOs: Integrated Disability Management and Managed Workers' Compensation Strategies and Products."

"There's already a growing demand for medical management and case management services, and few health maintenance organizations are in a financial position to respond to market demand," he says.

Granahan notes that individuals and organizations should be ready to

offer employers case management services and to form preferred provider organizations geared toward occupational medicine. Through those efforts, they will be able to build a substantial client base as workers' comp rates start to squeeze employers in the coming months, he says.

"The control of health care and those who see the value of case managers is switching from the hospital and community ballpark into the employer market. Employers control health care dollars and where they go, especially in this full employment economy," explains **Catherine H. Garner**, DrPH, RNC, FAAN, president of CareManagement.com, an Internet-based care management firm in Tucson, AZ. "This is a great time for case managers to go to employers and say, 'I want to work with you on improving your productivity.'"

Follow the trends

The key to successfully gaining an employer client base is to understand trends in the current workers' compensation market and the opportunities those trends offer to develop services that fill gaps in the current market, says Garner. However, case managers also must have the ability to market those services to employers using a language they understand, she adds.

Granahan and his colleagues report the following market trends in the fifth annual HMO survey report:

- Workers' comp rates are inadequate in most states to cover costs on the majority of lost-time claims.
- The costs of medical services, prescription drugs, and durable medical equipment continue to rise.
- There is a continued increase in the frequency and overall cost of workers' compensation and disability claims due to an increase in the number of employed workers, an increase in salaries of those employees, and a predicted increase in the number of occupational stress claims.

"I see case management as a total solution to this growing mess," says Garner. "Employers up until now have been most concerned about who shows up for work and what gets done when they are there. Now, with near full employment, they're starting to look at who doesn't show up for work and what's wrong with them."

Case managers must speak the language of employers and develop services that make sense to them, she notes. "Forget terms like 'healthy employees,'" Garner advises. "We need to get comfortable with terms like 'maximize your employees' potential.' Healthy people don't mean anything to an employer, but productivity — that means something."

The first step to developing services that appeal to employers is to identify the work force issues that impact employee productivity. Garner says those include:

- chronic disorders;
- illness / absence;
- preventable injuries.

Understanding the employee health issues that affect productivity should help case managers develop programs to address those factors that hurt employers' bottom lines, she says.

"Many health plans are doing integrated workers' comp / disability management, but all that does is bring the claim into one central location and then funnel it out where it needs to go. What if I have diabetes that is poorly managed? If nobody is helping me monitor my diabetes, and I drop this podium on my foot, the cost of managing my injury is going to be much higher. That's where case managers can develop products that make a difference to employers — in those 'no-care zones.'"

Services to consider

Here are Garner's suggestions for services that case managers should develop for the employer market:

1. **Risk profiling**. "Health assessments are easily administered in the workplace. They can be done on-line and blinded so that employers receive good information on their employees' health risk

COMING IN FUTURE MONTHS

- Using cost-based accounting to prove your worth
- Understanding the impact of culture on health practices
- New approaches to breast cancer treatment
- Rehabilitation by telemonitor for catastrophic injury follow-up
- Setting standards for managing children with complex needs

without breaching patient confidentiality," says Garner. "Once you've identified employee health risks, you can suggest targeted intervention programs."

In addition, understanding the health profile and demographics of the employee population also allows the case manager to make benefit recommendations that save the employer money. "For example, an employer probably doesn't need to spend money on extra maternity coverage if the average age of employees is 52. You can help employers design health plans that make sense for them and save money. That will make you very valuable to an employer client."

2. **Disease management**. "Many health plans offer disease management programs," Garner notes. "The problem is, if you work full time, exactly when do you attend a disease management program? How does the health plan reach you with good education and monitoring services?"

A growing number of employers are asking their health plans to provide disease management in the workplace where it is more accessible to employees, she says.

3. **Quantifying absenteeism**. Case managers also can help employers track absences and develop services that address the most common reasons for employee absence. "Many times we find the employees take sick days not for themselves, but to care for a sick child," says Garner. "It might be worth considering employee assistance programs that address that issue."

One employer with a high percentage of female employees found that many absences were related to employees keeping appointments for annual mammograms.

"At the urging of the company's occupational health nurses, the company brought family health clinics and mammogram machines to its sites with large numbers of female employees," says Garner. "The nurses began to add up absences and found that women lost a half day of work for their general physicals and another half day for their mammograms."

Quantifying absenteeism also helps case managers market occupational health and safety programs to employers. "What if you find that an employer has a great number of back injuries? Employers need to meet regulations for mandated worker safety programs. Case managers can deliver those programs."

4. **Job requirements/classifications**. "Case managers are well-qualified to review job descriptions and help employers determine at what point a person is not able to meet the job requirements of a specific position," says Garner.

As the population continues to age, she notes that employers may have a need for case managers to help them evaluate and accommodate an aging work force. "Employers have a great deal of fear about age discrimination right now. Case managers can help employers evaluate employees' production expectations and safety issues at different age levels."

5. **Benefit administration/coordination services.** "I predict that we are going to see an increase in the number of employers who tell their employees, 'Here is your $500 health care benefit. Go out and buy whatever coverage you want.' Several large employers have already adopted this type of policy," Garner says.

Employees already have sued their health plans for denied or delayed services. Garner says she sees a day in the near future when employees sue their employers, as well. "I don't believe it's too far-fetched that an employee decides to sue an employer for inadequate health care coverage," she says. "The next logical step after you've sued your HMO for denial of benefits is to sue the guy who bought the policy. That's why I believe many employers will get out of that business in the near future. When that happens, it will create a new opportunity for case managers at the same time."

Improving employee satisfaction

Garner says case managers should approach employers with employee health benefit education classes. "You can offer to help employees select the best plan for their particular health needs, or you can offer to have a counseling session where you explain the benefits covered by the employee's particular plan."

She suggests case managers approach the human resource and financial staff. "Ask them how many complaints they get from employees each year about their health insurance. Tell them you think you can help increase employee satisfaction and decrease complaints by walking employees through the fine print on their benefits packages."

Case managers also can offer counseling to employees on how to work with their health plans. "If a prescription isn't covered, where else can the employee turn to get that medication? Case managers have the answers to those questions. Employers rarely think in that regard, but they are consumers, too" she says. You can gain employer clients if you address those issues.

6. **Care coordination/nurse triage programs.** Most employees report satisfaction with their health care services once they enter their providers' offices, notes Garner. However, she says, employees report dissatisfaction with the time they are forced to wait to be seen by their physicians. "Case managers can offer employers a triage system that helps get patients into their provider's office in a more timely manner. Tell employers they'll have a more satisfied work force. Any time you can help manage one of those 'no-care zones,' you will help employers improve productivity."

An excellent place to start your entry into the employer market is your local chamber of commerce, Garner says. "I encourage you to sit through a few lunches with employers and listen to their concerns. Then, if an opportunity presents itself, educate them about case management and what it can do for them."

Getting started

Once you have a better understanding of the health care needs of local employers, there are several steps to getting an employer's business, she says:

- define the employer's problem;
- identify alternatives;
- identify the costs and benefits of each proposed intervention;
- present your findings in a one-page format;
- start small.

"You may have many ideas that you'd like to propose, but start small and build the relationship as you demonstrate your worth," she recommends. **(Several formulas for measuring success appear in the story on p. 147.)**

In addition, Garner says it's important for case managers to select a target market where they are most likely to achieve success. "Start with one or two very progressive employers who are willing to hang with you. Make sure the employer doesn't have a high turnover, too. You won't see a long-term benefit if the employer has high turnover." ■

Survey: HMOs struggle with workers' comp

Fewer HMOs offering managed workers' comp

The "Fifth Annual Milliman & Robertson Survey of HMOs: Integrated Disability Management and Managed Workers' Compensation Strategies and Products" report found a more than 20% drop in the total number of health maintenance organizations offering managed workers' compensation and integrated disability management services.

Milliman & Robertson's fifth annual survey was mailed to HMOs with a minimum group enrollment of 20,000 members, representing roughly 85% of the total national HMO marketplace. It asked HMOs what strategies and services they were currently offering or considering offering specific to managed workers' comp and integrated disability management.

Summary of findings

The report was co-written by **William L. Granahan**, CIC, LIA, CMC, a senior consultant and practice manager with Milliman & Robertson's Boston office. Key findings include:

1. HMOs are backing away from managed workers' comp programs. Active participation in those programs dropped from 70% of respondents in 1996 to 63% of respondents in 1997 to 41% in the recent 1998-1999 survey.

2. HMOs reported continued interest in integrated disability management services. However, most respondents reported little active participation in these programs at this time. Slightly more than 40% of respondents reported they were considering providing integrated disability management services, but only 11% reported offering any disability management services for nonoccupational claims.

(The box on p. 145 breaks down the types of managed care services HMOs offer to managed workers' compensation and integrated disability management clients.)

3. Larger HMOs with more than 250,000 group

(Continued on page 146)

Who's offering what?

The "Fifth Annual Milliman & Robertson Survey of HMOs: Integrated Disability Management and Managed Workers' Compensation Strategies and Products" report found that of health maintenance organizations offering managed workers' compensation and integrated disability management services:

- 75% provide clients with a toll-free number to expedite claims reporting from employees, employers, and providers.
- 25% offer clients early intervention to flag potential lost-time or high-cost claims.
- 75% offer clients telephonic and on-site case management services for lost-time claims.
- 50% offer clients utilization review services to monitor treatment protocols and medical service use.
- 63% offer clients rehabilitation services and return-to-work programs.
- 25% offer prescription drug programs.
- 13% offer durable medical equipment for disabled employees.

One reason few HMOs have turned a profit on their managed workers' comp and integrated disability is that they offer selected services and fail to implement a full managed workers' compensation model, says report co-author **William L. Granahan**, CIC, LIA, CMC, a senior consultant and practice manager with Milliman & Robertson's Boston office. "Done correctly, this model does work. However, if you don't put the model with all of its components together carefully, then it doesn't work."

He says that model includes:

❑ **Loss control and safety programs**. "This includes wellness programs and health screening. It doesn't sound much like workers' compensation, but it's an excellent first step in creating employer and employee awareness about health issues," he explains. "It goes far beyond the usual safety program, like making sure there are no banana peels on the floor, and includes things like cholesterol screening."

❑ **First report of injury**. "Many HMOs have trouble with this piece. There has to be a state-of-the-art information system for reporting injuries in the first 24 to 48 hours," he says. "The problem is these systems are expensive. HMOs can lease systems or partner with someone who has one. It should be able to manage all information associated with the claim."

❑ **Medical management**. HMOs should set up preferred provider organizations (PPOs) of occupationally trained physicians, Granahan notes. "We've consulted with hospital systems who put PPOs together that included gynecologists and gastroenterologists. This network has to be one composed of physicians that know musculoskeletal injuries, which make up the majority of workers' comp claims."

❑ **Case management**. HMOs must have nurse case managers who begin to manage workers' comp claims the minute they become lost-time claims, he says. "A case manager must be assigned to every lost-time case, even if the claim is only going to be managed telephonically. That case manager is the liaison between the employee, employer, and provider, holding everything together."

❑ **Return-to-work program**. This should be coordinated by the case manager, he says.

❑ **Outcomes measures**. "Many HMOs fail to deliver on the measurement piece. When you offer employers a service, those employers want to know how much you will decrease their overall claims."

Gathering outcomes data

Granahan admits that many HMOs lack adequate claims data to do an accurate outcomes study. "We're working on a benchmarking study right now, and we're hoping to prove that medical and case management reduced overall claims costs," he says. Granahan and his colleagues are comparing the total cost of workers' comp claims in a retail food company with a managed workers' comp model to a retail food company without a managed workers' comp model. The two have the same parent company and similar demographics.

"Most of the data captured on workers' comp claims over the years have been financial data. We can look at the cost of the claim, but we're not sure we can look at what type of treatment was provided," he notes. "We do hope we can compare back injury claims in one company to back injury claims in the other and find that the claims in the company with the managed workers' compensation model were two months shorter and somewhat less expensive." ■

How they pay providers

The "Fifth Annual Milliman & Robertson Survey of HMOs: Integrated Disability Management and Managed Workers' Compensation Strategies and Products" report found that of health maintenance organizations offering managed workers' compensation and integrated disability management services:

- 35% reported using state fee schedules as their No. 1 provider reimbursement model.
- 30% reported using a fee-for-service reimbursement model.
- 23% reported using a case rate reimbursement model.
- 9% reported using a provider capitation as a reimbursement model.

"Many analysts expected provider capitation to become the prominent reimbursement model for managed workers' comp programs, but this year's survey again indicates that very few respondents use a capitation model for reimbursement," notes report co-author **William L. Granahan**, CIC, LIA, CMC, a senior consultant and practice manager with Milliman & Robertson's Boston office.

The main obstacle to using a capitated approach to managed workers' comp and integrated disability management programs appears to be the long-term nature of workers' comp claims, he notes. In addition, the variability in the types of illnesses and injuries and the inadequacy of historical data needed to establish capitated models appear to be deterrents, Granahan says. ■

health members continue to be the most likely to offer managed workers' comp and integrated disability management services.

4. Seventy-nine percent of HMOs identified the desire to increase their current health care employer client base as their primary motivation for offering managed workers' comp and integrated disability management services.

5. Seventy-one percent of HMOs reported increased revenue as their primary motivation for offering these services.

6. Forty-three percent of HMOs reported greater market penetration as their primary motivation.

7. HMOs actively providing managed workers' comp and integrated disability management services reported that occupational injuries and lost-time claims represented less than 10% of their revenue.

8. Roughly 50% of HMOs actively providing managed workers' comp and integrated disability management services reported that 70% or more of their group health primary care physicians were included in occupational health networks. **(The box at left breaks down the types of payment mechanisms HMOs use to reimburse providers.)**

9. Roughly 65% of the HMOs actively providing managed workers' comp and integrated disability management services reported linking up with external vendors to supplement their programs. Of those, roughly 40% reported partnerships with workers' comp insurers, 23% reported partnerships with third-party administrators, and 30% reported partnerships with case management firms.

10. Total medical and indemnity cost savings estimated by HMOs actively providing managed workers' comp and integrated disability management services were between 20% and 30%. However, the authors note that it is unclear what data were used to determine those employer savings.

11. Most HMOs listed tracking patient outcomes as a key objective, yet a majority did not provide data on the average duration of lost-time cases.

"Duration of lost-time cases is a key measure of the true efficacy of a managed workers' comp program, and HMOs offering these services aren't able to measure the most important cost savings generated by their intervention — the replacement wage benefits saved by a more rapid return-to-work program," Granahan says.

(For information on Milliman & Robertson's fourth annual survey, see *Case Management Advisor,* March 1999, pp. 45-47. For a discussion of business opportunities for case managers in the current workers' compensation market, see cover story.) ■

Four business strategies for CM success

Here's what it takes to compete

Case managers have the know-how to solve many of the problems facing the health care industry, but they aren't always comfortable with the business skills necessary to translate that know-how into an action plan that gains the necessary financial backing.

"Case managers have the key indicators for business success listed by most business leaders," says **Ann White**, RN, PhD, MBA, CNA, undergraduate nursing coordinator at the University of Southern Indiana in Evansville. "They know how to be alliance thinkers and systems thinkers. They know how to negotiate and manage complex relationships. They just aren't comfortable with the actual business skills — the formulas needed to gain appreciation and support for what they do."

White says case managers must master the following four business skills to succeed no matter what their practice setting:

1. **Strategic planning**. "Few people enjoy strategic planning, but it's an essential first step to any new product or business venture," says White. The steps of strategic planning are:
   — assessment of current status;
   — critical inquiry;
   — reflection;
   — action plan;
   — evaluation.

"People are generally good at critical inquiry. They put feelers out and assess the current market. What they don't spend enough time on is reflection," says White. "They gather all their information and then rush to put their strategic plan together just to get it out of the way."

White suggests case managers gather their information and then put it away for a while before continuing with the strategic planning process. "I don't know about you, but I do most of my best thinking in the car. It's a perfect time to sit and reflect. Let that information sit around and mush around for a while. It's sometimes difficult to think about where you want to go."

One strategic planning method White says has worked well for several small to medium-size companies she's worked with is "story boarding."

"Story boarding is an old method, but it works well for some situations," she says. "Once you've completed your critical inquiry, bring 10 to 20 staff members together and give them each three index cards. Have them write one idea on each of those three cards in answer to the question: What would you like to see this company doing in three years?"

After everyone has filled out their cards, White says the cards should be grouped by similarity. Each participating staff member then gets to vote on two ideas, using stick pins or stickers to mark their votes. Whichever ideas get the most votes become part of your strategic action plan for the next period. "You've vested your employees in the process, and because they've been a part of the plan from the beginning, they will be interested, motivated, and work hard to make that plan succeed."

2. **Business plans**. "The business plan helps you focus on the critical issues of a new project or service. It helps you organize your ideas, market your service, and gain financial backing," says White.

Although every organization uses a slightly different format for its business plans, she says business plans have the following eight sections:
   — executive summary;
   — description of the present situation;
   — objectives;
   — management structure or plan;
   — product/service description;
   — marketing plan;
   — finance plan;
   — appendix.

"Your executive summary is the first piece that goes into your business plan, and it's the most important," says White. "I don't know how many times I have had business executives tell me that the executive summary is all they read. If they don't like the executive summary, then you've slaved more than 20 pages that will never be read."

One way to start developing your business plan is to write what White calls the "unique selling advantage" of your service. "Write in two sentences what the product or service is; you only get two sentences. If you can do that, then the rest of your business plan will flow. If

you have trouble articulating your service in those two sentences, then your entire business plan is going to reflect that, and it will be difficult for you to gain the financial support you need."

White often suggests writing the executive summary last. "It really doesn't matter whether you write it first or last. What does matter is that it must be concise — no more than one page."

The executive summary should also answer these four questions:

- What is the service?
- How will I market the service?
- How will I get paid for that service, and what are my overhead costs?
- Is there a future in it?

"If your executive summary is concise and answers those four questions, then that financial backer is going to say, 'Wow! I have to read the rest of this because I want to know more about what this person is going to do,'" says White.

Define your market

Another section of the business plan that seems to challenge many people is the market analysis and target population, she notes. "Whom are you going to sell this service to? If you've identified a service for high-risk obstetric patients, that's nice, but be as specific as possible so that people can really understand exactly what you are trying to do."

Your market must be definable, meaningful, and reachable, she adds. "I worked with a group who wanted to open a health clinic for homeless children. They had all the elements for their business plan except for the 'reachable' part. How do you reach a group of children who are homeless? That was a real challenge. You must look at your target audience from every perspective."

The last section of the business plan also gives people difficulty, notes White. "Most financial backers will ask that your business plan include an income and an expense report. Many computer programs can create balance sheets for you, but you still have to know what numbers to put into the computer," she says.

Your income report should include not only the fees you will charge, but any deductibles and discounts, she notes. "Spell everything out. Identify exactly what you are planning."

Case managers don't have to struggle alone on their business plans, she adds. "Your local chamber of commerce will have retired business people who will assist you at no charge. You can walk in and find a retired banker who can help put your numbers together for you."

A break-even analysis is one common strategy you may choose to use for your financial section. "Most economists apply this method to manufacturing, but I still find it useful. It's a way to calculate how much money you will need to generate to cover your expenses. It helps you predict what profit you might expect," says White.

In a break-even analysis, Q equals fixed costs over price minus variable costs:

- Q is the break-even quantity, or the number of services you must provide or patients you must see to break even.
- Fixed costs are those costs you will have every month, whether you see one patient or 200.
- Price is the fee for your service.
- Variable costs are those associated with each service you provide.

Here's an example of that equation: If your fixed costs were $10,000 per month, your fee was $500 per service, and your variable costs were $100, Q would equal 25.

"Using these figures, you must provide 25 services per month to break even," says White. "If you can see doing that, than you have a viable service. If you can't see providing 25 services per month, then you may want to rethink this service."

White urges case managers to keep each section of their business plan brief. "Busy executives don't want to read a lot of narrative. Cut to the chase. Keep your patient demographic description to one paragraph. Provide an overview of your service, not a nursing care plan."

Additional detail can be provided in an explanation at the end, she notes. "If you've written a cost-benefit analysis, add a subscript and refer people to a note at the end. That note can provide an explanation of how your potential charges were calculated on historical data for the past three years from Institution X. Now, you've got their attention. You've shown you have the data and you know what you're talking about."

3. **Negotiation.** White says there are three basic steps to any successful negotiation: time, information, and power. "It took me a long time to figure out how to negotiate anything until I realized we negotiate all the time — with our friends, our children, our spouses, our co-workers," she says.

Before you even begin negotiating, make sure you're talking to a decision maker. "Don't waste

(Continued on page 153)

Reports From the Field™

New drug/product updates

FDA approves growth drug

The Food and Drug Administration in Rockville, MD, recently granted orphan drug status for somatropin for injection in the long-term treatment of growth failure in children with Prader-Willi syndrome, a rare genetic disorder that causes short stature, an involuntary continuous urge to eat, low muscle tone, and cognitive disabilities.

In two randomized, open-label, controlled clinical trials, 23 children with Prader-Willi syndrome received somatropin. A control group received standard care. At the end of the first year of treatment, there was a clinically and statistically significant difference in the mean change in height between the treatment and control groups in both studies.

Body composition benefits

Linear growth continued in the second year when both the study groups and the control groups received treatment with somatropin. In addition, the drug produced beneficial effects on body composition at one year, with an increase in lean body mass and decrease in fat mass. There was no apparent impact on body weight.

In the United States, Genotropin Lyophilized Powder (somatropin [rDNA origin] for injection), manufactured by Pharmacia & Upjohn in Peapack, NJ, has been approved for the long-term treatment of children with growth hormone deficiency (GHD) since 1995 and adults with GHD of either childhood or adult onset since 1997.

Case managers with clinical questions about somatropin can call (800) 253-8600 or visit the company's Web site at www.genotropin.com. ▼

Skin substitute heals diabetic ulcers

Novartis Pharmaceuticals in East Hanover, NJ, recently announced it has received Food and Drug Administration approval for Apligraf (Graftskin) for use with conventional diabetic foot ulcer care in the treatment of diabetic foot ulcers of greater than three weeks' duration.

In a clinical trial of more than 200 patients with diabetic foot ulcers, Apligraf was shown to heal more diabetic foot ulcers faster than conventional therapy alone. By 12 weeks of treatment, 56% of diabetic foot ulcers treated with Apligraf were 100% closed, compared with 39% of ulcers treated with conventional therapy alone.

Apligraf consists of living skin cells and structural protein. The lower dermal layer combines bovine type 1 collagen and human dermal cells, producing additional matrix proteins. The upper epidermal layer is formed by prompting human epidermal cells first to multiply and then to differentiate to replicate the architecture of human skin. Unlike human skin, Apligraf does not contain melanocytes, macrophages, lymphocytes, blood vessels, hair follicles, or sweat glands. ▼

FDA agrees product heals tough fractures

Orthofix International in Richardson, TX, recently received notice from the Food and Drug Administration that its patient registry data for the Orthofix Physio-Stim bone growth stimulator have been approved.

The Physio-Stim is a nonsurgical treatment that aids in the healing of fractures that will not heal on their own. Researchers studied 729 patients with a total of 859 fractures that had not healed on their own by a minimum of two months. Using the Physio-Stim bone growth stimulator alone, nearly 85% of those patients were able to attain fracture healing. Nearly 50% of those patients previously had undergone one or two procedures such as internal/external fixation, which failed to heal their fractures. ▼

Drug promotes better sleep

Provigil Tablets (modafinil), manufactured by Cephalon in West Chester, PA, increased daytime wakefulness in patients treated with continuous positive airway pressure for sleep apnea.

Results of a multicenter, double-blind, placebo-controlled study of 157 sleep apnea patients indicate that patients who were treated with modafinil performed better on validated tests of excessive daytime sleepiness as measured by standardized scales. The most common side effects were headaches, nervousness, nausea, anxiety, and dizziness.

Cephalon recently initiated additional clinical trials with modafinil in sleep apnea patients with the intention of pursuing a label extension to include this additional indication. The drug is currently marketed in the United States for the treatment of excessive daytime sleepiness associated with narcolepsy. ▼

Gel contains no preservatives

Carrington Laboratories in Irving, TX, recently received approval from the Food and Drug Administration to market a new sterile and preservative-free hydrogel containing aceman-nan hydrogel. The new product will be available this month under the brand name Ultrex, and was specifically formulated for unit-dose use in patients with sensitive skin.

Ultrex preservative-free gel is indicated for the management of pressure and stasis ulcers, post-surgical incisions, first- and second-degree burns, and skin conditions associated with peristomal care.

For more information, visit the company's Web site at www.carringtonlabs.com. ■

Orthopaedics

Study says repetitive use not to blame for common injuries

There's no basis to industrial claims that work-related repetitive use causes seven common foot and ankle problems, according to a study presented at the annual meeting of the American Orthopaedic Foot and Ankle Society (AOFAS) held recently in Orlando, FL.

"We found it difficult to distinguish long-term foot and ankle problems as a result of daily activity from those that were job-related," notes the study's first author, **Gregory P. Guyton**, MD, assistant professor of orthopaedic surgery at the University of North Carolina in Chapel Hill. "Walking is walking, whether it's done at work or outside work," he says.

Clinical and legal perspectives

The concept of cumulative occupational trauma in the foot and ankle has generated interest in both the medical and legal communities. An increasing number of industrial claims have been filed for foot and ankle repetitive motion problems, similar to claims for arm, wrist, and hand injuries as a result of computer use in the workplace, according to AOFAS.

"For example, an employee could say they developed a bunion because they're on their feet all day at work," says Guyton. "But the bunion could be caused by the type of shoes they wear in their leisure activities."

Researchers reviewed literature on work-related foot and ankle problems published in English-language medical journals in the past 25 years. The study looked at these common

disorders: arthritis of the foot and ankle, toe deformities, pinched nerves between the toes, heel pain, adult-acquired flat foot, and tarsal tunnel syndrome, which is increased pressure on the major nerve of the foot as it passes the ankle.

Researchers applied three criteria to the available data for each disorder:

- increased prevalence of disorder within a particular industrial population;
- evidence that isolated the disorder as job-related rather than from daily activities;
- whether a particular industrial environment would cause disorders in a normal person if he or she were exposed to it.

Researchers say the study will have an impact on both the medical and legal arenas, says co-author **Roger A. Mann**, MD, of Oakland, CA. "Employers will not have to spend money to settle industrial claims which have no merit," he says. ▼

Artificial ankle joints give hope to arthritis sufferers

New artificial joints hold promise for ankle arthritis, according to experts speaking at the recent annual meeting of the American Orthopaedic Foot and Ankle Society in Orlando, FL.

Promise aside, new prosthetic devices for total ankle replacement remain an experimental procedure, and caution is advised, says symposium moderator **Lowell Gill**, MD, with the Miller Orthopaedic Clinic in Charlotte, NC. "Twenty years ago, total ankle prostheses met with a high failure rate due to loosening, subsidence, or sinking of the device into the bone, and wound complications," he notes. "Because of these high failure rates of the past, total ankle replacement remains an experimental procedure. However, reports on the newer prostheses to date are encouraging."

The length of time for follow-up reports on the newer devices remains short-term to mid-term with no long-term studies reported yet, says Gill. "The short- and midterm follow-up studies on total ankle replacement 20 years ago also were encouraging, but these devices ultimately failed," he cautions. "In the short term, total ankle replacement does appear to provide pain relief and reasonable function."

Ankle joint prostheses have marked design limitations because of the small size of the talus bone in the ankle, he notes. "Soft tissue complications such as wound healing problems remain a difficult challenge since this area of the body is less forgiving than in more proximal joints like the hip or knee." ■

Cardiology

Drug combo provides better cholesterol control

Hormone replacement therapy and simvastin taken together produce more favorable changes in cholesterol profiles than either therapy alone, according to research presented at the annual meeting of the American College of Cardiology in Anaheim, CA.

The well-controlled study of 139 postmenopausal women with hypercholesteremia compared the separate and combined effects of hormone replacement with conjugated estrogen / mexoxyprogesterone acetate tablets and simvastin.

After six weeks of treatment, 79% of women on combined therapy achieved the clinical goal of lowering LDL cholesterol to a mean baseline of 194 mg / dL, compared with 59% of women on simvastin alone and 32% of women on hormone replacement alone. Percentage declines in LDL cholesterol were 37% for women on combined therapy, compared with 29% and 17% respectively for women on simvastin alone and women on hormone replacement alone.

"Cardiovascular disease is the leading cause of death in women. This combination of therapies is a promising way to significantly lower cholesterol levels, thus reducing women's risk of developing cardiovascular disease and experiencing acute events such as heart attack and stroke," says **Michael H. Davidson**, MD, FACC, president of the Chicago Center for Clinical Research. "Women with elevated cholesterol levels should talk with their doctors about the therapy that is best for them."

Researchers also measured changes in total cholesterol and levels of HDL, or good cholesterol. Both therapies alone and in combination improved HDL levels by 4% to 13% and reduced total cholesterol levels by 9% to 24%. ■

Oncology

Study: Surgery unneeded for prostate cancer

Radioactive seeds produce good outcomes

The results of a 12-year study indicate that brachytherapy, or implanting radioactive seeds into the diseased prostate, is as effective as removing the prostate surgically with shorter recovery and fewer side effects such as incontinence and impotence. The study was presented at a medical meeting of radiation oncologists held recently in Washington, DC.

"Increasingly, patients are seeking, if not demanding, accurate estimates of their prognosis," explains study author **Haakon Ragde**, MD, medical director of prostate brachytherapy at Northwest Hospital in Seattle.

"Physicians also require such estimates, based on the most precise and up-to-date information, when planning therapy," Ragde says. "For the clinician and patient alike, a vital question has long awaited an answer: Is brachytherapy effective in the long term?"

Impressive cure rate

Ragde says the answer to that question is a resounding "yes." The Northwest Prostate Institute now has data on 215 consecutive patients treated with brachytherapy with a 12-year observed follow-up. The overall cure rate is 70%, equal or better than the best cure rate reported for any other prostate cancer treatment, Ragde reports.

Roughly 80% of those patients were considered at high risk for extra-prostatic extension of the malignancy based on the size of the module and prostate-specific antigen levels; they were treated with a combination of external beam radiation therapy and seeds. The cure rate at 12 years for those high-risk patients was 79%.

In addition to its excellent cure rate, brachytherapy has several other advantages to traditional radical prostatectomy and external radiation, notes Ragde. Those include:

- Brachytherapy is performed on a cost-effective outpatient basis.
- The patient is in the operating room no more than 45 minutes and is discharged from the outpatient facility about two hours later. ■

Geriatrics

Study finds Alzheimer's estimates too low

Current estimates in the literature put the number of people in the United States with Alzheimer's disease at roughly 4 million, but a study presented at the recent World Alzheimer Congress 2000 in Washington, DC, suggests the actual number is much larger.

Researchers examined the rate of change in memory function during a six-year period in nearly 750 nuns, priests, and brothers participating in the Religious Orders Study, a longitudinal, clinical-pathologic study of aging and Alzheimer's disease. In addition, study author **David Bennett**, MD, director of Rush Alzheimer's Research Center at Rush-Presbyterian-St. Luke's Medical Center in Chicago, measured the amount of Alzheimer's disease pathology in the first 100 participants who had a brain autopsy.

Bennett and his colleagues found that people with mild cognitive impairment declined much faster on memory tests than people with no cognitive impairment. In addition, Alzheimer's disease pathology already was present to a large degree in people who died with mild cognitive impairment.

Researchers also examined the relation of Alzheimer's disease pathology to memory function just prior to death and to rates of change in memory several years prior to death. Alzheimer's disease pathology was related to both. Overall, the data suggest that many people with mild memory problems who do not meet conventional criteria for dementia are exhibiting the pathology of Alzheimer's disease.

"Often these people are not diagnosed with Alzheimer's or told that their mild memory loss is part of normal aging," he says. He notes that this research indicates the magnitude of the public health problem posed by Alzheimer's may be even larger than commonly recognized, and that increased funding for clinical care and research is needed to effectively combat this disease. ■

(Continued from page 148)

your time negotiating with someone who does not have the power to make decisions about using your services," she urges. A tactful way to determine whether the person you've contacted has the power to make decisions is to simply ask: Who besides yourself will have to sign off on this decision? "If they say Mr. X, then pull in Mr. X. If they say they have the power to make the decision, go forward," she says.

The first step in your actual negotiation is to prepare. "Have at least three plans ready. Plan A is the Cadillac version. Plan B is your Chevy version. Plan C is your absolute minimum VW version — what you absolutely must have. You have to go into every negotiation knowing that minimum. It's critical because it helps you establish what you can give up and what you can't," explains White. "I also encourage people to talk to themselves in the mirror or while driving in the car. Plan out everything you are going to say. If you do, when the actual negotiation begins, you are more comfortable with it."

If you're negotiating in person, don't overlook your appearance, she suggests. "You want to feel your best. Put on your best suit. It will give you confidence."

Whether you are negotiating in person or by telephone, always follow up immediately with a written summary of the key points, White says. "If I'm on the phone, as soon as I hang up, I write a letter. That letter simply says, 'It was nice to talk to you today. This is a summary of the events according to my notes.' Then send it out as quickly as you can."

If you delay too long before sending a written summary of your negotiated points, the other party may forget key points. "They wonder, 'Did we really say that?' If you send that letter immediately, you've got them," White notes.

4. **Marketing strategies.** Marketing is not advertising, White stresses. The goal of marketing is to catch the attention of the person you would like to buy your service without the appearance that you're advertising, she explains.

"You want to identify the needs of your target consumer and then let them know how you can fill [them]," she says. "If your consumer is an employer and your service is case management, you can send a one-page cost-benefit analysis. An employer will notice that."

White encourages case managers to keep a marketing portfolio of competitors' marketing materials that appeal to them. "If something grabs your attention, put it in your portfolio. There is no need to reinvent the wheel."

Case managers shouldn't allow their lack of business skills hold them back from seizing opportunities in today's health care market, says White. "If your local chamber of commerce can't help you, go to the business school at your local college or university," she suggests. "I taught a marketing course and required students to do a market analysis and business plan for local companies. It was student work, so it wasn't the Cadillac version, but it was free information that those companies didn't have before. You can take it from there and run with it." ■

Long-term care/geriatrics

FDA approves new Alzheimer's treatment

Drug slows decline in early Alzheimer's

The Food and Drug Administration in Rockville, MD, recently granted marketing clearance for Exelon (rivastigmine tartrate) capsules, a cholinesterase inhibitor for the treatment of mild to moderate Alzheimer's disease, manufactured by Novartis Pharmaceuticals in East Hanover, NJ.

Exelon therapy has proven effective in multiple phase III trials in the three key domains used to assess Alzheimer's — activities of daily living, behavior, and cognition, according to **George T. Grossberg**, MD, director of the division of geriatric psychiatry at Saint Louis University School of Medicine.

"When an Alzheimer's patient declines in any one of the three domains of the disease, it has a major impact on the lives of patients and their caregivers," he says. "Early diagnosis and treatment are extremely important. A new therapy such as Exelon, which can affect symptoms early in the disease and is proven effective in all three critical domains of the illness, provides hope for Alzheimer's patients and their caregivers."

In clinical trials, on average, patients treated with Exelon were considered clinically improved

at the end of six months, compared with those receiving placebo. During the clinical trials, patients treated with 6 mg/day to 12 mg/day of Exelon were far more likely to experience substantial cognitive improvement and far less likely to show substantial decline than did the average placebo-treated patient.

Other findings from clinical trials include:

• At 26 weeks, 81% of patients given 6 mg/day to 12 mg/day of Exelon had greater improvement in, or less worsening of, cognitive function than did the average placebo-treated patient.

• Exelon patients demonstrated significant improvement compared with placebo patients in areas such as total word recall and recognition, orientation, and ability to speak.

• Patients given Exelon demonstrated fewer delusions and engaged in fewer purposeless activities than placebo patients.

• Higher therapeutic doses of Exelon were associated with greater benefit.

For more on Exelon, call (877) 439-3566 or visit the company's Web site at www.novartis.com. ■

Medicare patients lose access to nursing homes

Report paints gloomy picture of PPS' impact

The percentage of nursing home residents whose care was paid for by Medicare fell for the first time in recent history under Medicare's new prospective payment system, according to data reported in the recently released *Nursing Home Statistical Yearbook, 1999,* published by the American Association of Homes and Services for the Aging (AAHSA) in Washington, DC. In fact, the report reveals that only 8.7% of nursing home residents had Medicare as their primary payer, the lowest percentage since 1996 and down from a high of 9.4% in 1998.

"These numbers underscore the danger to Medicare beneficiaries of losing access to quality nursing home care if we underfund our system of nursing home care," says **Len Fishman**, immediate past president of AAHSA.

Other findings of the report include:

• The total number of Medicare- and Medicaid-certified nursing home beds has fallen for the first time from 1.726 million certified beds in 1998 to 1.724 million in 1999.

• Not-for-profit nursing homes were cited for an average of 4.11 deficiencies, compared with 6.19 deficiencies in for-profit homes.

• The total number of nursing homes in the United States declined by 175 from 17,258 in 1998 to 17,083 in 1999.

• The occupancy rate of nursing homes in the United States remained constant at 82.7%.

• More than 70% of new nursing home residents need help with at least four activities of daily living.

• More than 47% of new nursing home residents need help with all five activities of daily living.

AAHSA publishes the yearbook annually as a compendium of statistics about the nursing home industry drawn from the databases of the Health Care Financing Administration (HCFA) in Baltimore. It reports on the characteristics of residents, staffing, and survey deficiencies.

"Although we would never claim the survey data collected by HCFA to be an adequate indicator of quality of care, until a better system is developed, it continues to be the only national measure of nursing home performance we have," says Fishman.

Copies of the yearbook are available for $70 to AAHSA members and $95 for nonmembers, plus $7 shipping and handling. To order, call (800) 508-9442 or fax (770) 442-8633. For more information, visit www.aahsa.org. ■

Use these 10 quick safety checks to avoid accidents

Follow with four simple solutions

Case managers know that preventing falls is vital to keeping seniors safe and comfortable at home. One in three seniors falls at least once, with 60% of fatal falls occurring in the home, according to the Brain Injury Association in Alexandria, VA. The good news is that many falls can be prevented with minor home modifications.

"We strongly advocate the prevention of accidents," says **Andrea Tannenbaum**, president of Dynamic Living in Bloomfield, CT, an on-line catalog of products that promote a safe home environment for seniors and the disabled. She suggests that case managers ask seniors or their caregivers these questions to help assess home safety:

✔ Is the lighting adequate, especially near stairs, hallways, and the front door?

✔ Are light switches easy to turn on and off?

✔ Are there a telephone and a lamp on the nightstand near the bed?

✔ Is there a night light in the bathroom?

✔ Is there clutter on the floors, especially around pathways?

✔ Are there any broken floorboards, tears in the linoleum or carpet, or abrupt changes in flooring such as thresholds, that could cause tripping?

✔ Are throw rugs secured to the floor?

✔ Does the bathroom/shower have nonskid flooring?

✔ Is there a tub/shower seat in the bathing area?

✔ Are there sturdy grab bars where falls most frequently occur: by the stairs, by the bathtub, and by the toilet?

Most case managers are familiar with the use of grab bars in bathrooms, but Tannenbaum notes that grab bars should be installed in other areas as well. "Install grab bars throughout the home, especially in areas that require frequent sitting and standing," she suggests. "Many wall-mounted grab bars can be found at local hardware stores or pharmacies. However, because seniors rely on a grab bar to hold them as they exert pressure, we suggest a professional installation." **(For information on how to find a qualified environmental access contractor, see *Case Management Advisor,* July 1999, pp. 113-115.)**

There are now many grab bar options on the market, adds Tannenbaum. Two models with which she says case managers may not be as familiar are:

• **SuperPole**. This is a floor-to-ceiling tension pole that can be installed easily to aid in standing or sitting anywhere in the home. "Unlike the wall-mounted grab bars, you don't have to be near a wall," she notes.

• **Advantage Rail**. This is a floor-mounted support bar with a handle that pivots to move with seniors in small, safe steps. "It can also lock in an instant to assist you to a seated position," says Tannenbaum.

Another potential hazard is inadequate light. "Because of the age-related changes in vision, more lighting is needed to do familiar tasks," she says. "It also takes the eye longer to focus when there are changes in lighting."

She suggests case managers recommend these two vision aids to seniors clients with failing eyesight:

• **Voice-activated light switch**. This device eliminates fumbling in the dark to turn on a light. The switch is activated by the human voice. It can also be used to activate fans and radios, she notes.

• **MotionPAD**. This device can be placed around the house to provide warning of an upcoming stairway or other obstacle. "Recordable messages are activated when someone walks by," she says.

Tannenbaum urges case managers to discuss home modifications with seniors while they are still in a healthy physical condition. "The financial burden is minimal compared to the potential risk of injury."

The Dynamic Living catalog can be accessed at www.dynamic-living.com. Or call (888) 940-0605. Dynamic Living also locates products in response to specific individual needs. ■

Disease management: AIDS conference

Study: Triple-nucleoside combination works

Two studies comparing the triple-nucleoside regimen of abacavir sulfate plus lamivudine/zidovudine with triple-drug regimens containing protease inhibitors as first-line antiretroviral therapy in therapy-naive patients found the triple-nucleoside regimen effective and patient tolerance and adherence high, researchers told colleagues at the recent XIII International AIDS Conference in Durban, South Africa.

In a study of 342 antiretroviral-naive patients, patients were randomized to receive either the triple-nucleoside regimen of abacavir sulfate plus lamivudine/zidovudine or indinavir plus lamivudine/zidovudine for 48 weeks. Patients on the first regimen took one abacavir sulfate and one lamivudine/zidovudine twice a day without dietary restrictions. Patients on the nucleoside plus protease inhibitor regimen took two indinavir tablets every eight hours and one lamivudine/zidovudine tablet twice daily. The patients taking indinavir were required to take the tablets one hour before or two hours after a meal and drink one and a half quarts of water a day.

Patients were stratified according to baseline

plasma viral load, with 63% having a viral load greater than 5,000 copies / ml but less than 100,000 copies / ml, and 37% having a viral load greater than 100,000 copies / ml.

At 24 weeks, 68% of patients on abacavir sulfate plus lamivudine / zidovudine had a viral load of less than 400 copies / ml, compared with 57% on the indinavir plus lamivudine / zidovudine regimen. Of the 245 patients for whom data were available from the more sensitive <50 copies / ml assay, 79% of patients on the abacavir sulfate plus lamivudine / zidovudine regimen were below the threshold, compared with 73% on the indinavir plus lamivudine / zidovudine regimen.

Adherence findings

Other findings include:

• Among patients whose baseline viral load was less than 100,000 copies / ml at baseline, 87% of the abacavir sulfate plus lamivudine / zidovudine patients achieved a viral load of less than 50 copies / ml, compared with 81% of patients in the other group.

• In patients whose baseline viral load was above 100,000 copies / ml, 65% in the abacavir sulfate plus lamivudine / zidovudine group achieved a viral load of <50 copies / ml, compared with 63% in the other group.

Adherence was self-reported by patients using the Treatment Assessment and Satisfaction Questionnaire, a validated measure of adherence. Researchers found that 74% of patients on the abacavir sulfate plus lamivudine / zidovudine regimen reported taking all antiretroviral doses over the previous four weeks or missed less than one dose per week, compared with 45% of patients in the indinavir plus lamivudine / zidovudine group. Only 6% of patients in the abacavir sulfate plus lamivudine / zidovudine group reported that their regimen was difficult to take as scheduled, compared with 38% in the other group.

"These early data offer important information about this triple-nucleoside regimen," says **Pedro Cahn**, MD, director of Fundacion Huesped in Buenos Aires, Argentina, and principal investigator of the study.

In a second study by French researchers, 195 patients were randomized to receive either one abacavir sulfate tablet plus one lamivudine / zidovudine tablet twice a day without dietary restrictions or three nelfinavir tablets every eight hours and one lamivudine / zidovudine tablet twice a day for 48 weeks. The median CD4 cell counts at baseline were 387 cells / ml in the first group and 449 cells / ml in the second group.

Findings include:

• 67% of patients in the abacavir sulfate plus lamivudine / zidovudine group had a viral load below 50 copies / ml and 72% had viral load below 400 copies / ml, compared with 66% below 50 copies / ml and 71% below 400 copies / ml in the other group.

• The median CD4 cell count increase was 91 cells / mm^3 in the abacavir sulfate plus lamivudine / zidovudine group and 65 cells / mm^3 in patients the other group.

• Ten patients on the abacavir sulfate plus lamivudine / zidovudine group experienced serious adverse events, including anemia, retinal detachment, and acute confusional psychosis.

• Four patients on the nelfinavir plus lamivudine / zidovudine group experienced serious adverse events, including depression, diarrhea, and hepatic cytolysis.

Abacavir sulfate is manufactured under the brand name Ziagen by Glaxo Wellcome in Research Triangle Park, NC. Lamivudine / zidovudine is also a Glaxo product manufactured under the brand name Combivir. For details on either drug, visit www.glaxowellcome.com or drug-specific sites at www.ziagen.com and www.combivir.com. ■

Drug suppresses virus, boosts CD4 count

People living with HIV who received nelfinavir mesylate combination therapy for three years were shown to experience suppression of virus as well as replenishment of CD4 cells, according to a study by U.S. researchers reported at the recent XIII International AIDS Conference in Durban, South Africa.

In this multicenter observational study, 56 therapy-naive HIV-infected individuals received nelfinavir mesylate (750 mg three times daily) in combination with standard doses of lamivudine / zidovudine. At the start of the study, individuals had a mean viral load of 204,000 copies / ml and a mean CD4 count of 310 cells / mm^3.

After three years, 76.9% of patients had a viral load of <50 copies / ml and an increase in their CD4 count to a mean of 556 CD4 cells / mm^3.

Nelfinavir mesylate is manufactured under the

brand name Viracept by Agouron Pharmaceuticals, a wholly owned subsidiary of Pfizer with headquarters in La Jolla, CA. For more details, visit the company's Web site at www.agouron.com. ■

Investigational drug shows promise

The first data from an ongoing Phase II study show an investigational protease inhibitor from Abbott Laboratories in Abbott Park, IL, reduces viral load in multiple protease inhibitor-experienced patients.

In this study, presented at the recent XIII International AIDS Conference in Durban, South Africa, ABT-378r inhibitor (lopinavir / ritonavir) was used in conjunction with the nonnucleoside reverse transcriptase inhibitor efavirenz and nucleoside transcriptase inhibitors.

Efavirenz is known to decrease the levels of some drugs in the blood. The study set out to evaluate the pharmacokinetics, efficacy, and safety of a regimen containing ABT-378r and efavirenz along with investigator-selected nucleoside reverse transcriptase inhibitors in multiple protease inhibitor-experienced patients, according to lead investigator **Jurgen Rockstroh**, MD, of the University of Bonn in Germany.

Researchers randomized 57 patients to receive either a dose of 400 / 100 mg of ABT-378r in three capsules twice daily or 533 / 133 mg in four capsules twice daily with a once-daily dose of efavirenz and investigator-selected nucleoside reverse transcriptase inhibitors.

Encouraging results

At week 24, 69% of patients taking the three-capsule dose and 82% of patients taking the four-capsule dose had viral load below 400 copies / ml. The average CD4 count increased 48 cells / mm^3 in the three-capsule group and 41 cells / mm^3 in the four-capsule group.

ABT-378r levels achieved with the three-capsule dose are reduced when co-dosed with efavirenz, report researchers. Blood levels of ABT-378r with the four-capsule dose in the presence of efavirenz were similar to the blood levels of ABT-378r achieved with the three-capsule dose without efavirenz.

"We are encouraged by these preliminary results from this ongoing study," says Rockstroh. "The ability to achieve viral suppression in patients previously treated with multiple protease inhibitors continues to be a significant challenge."

Through 24 weeks, three patients discontinued ABT-378r because of side effects. The most commonly reported side effects were diarrhea and general fatigue.

For more on ABT-378r, visit Abbott's Web site at www.abbott.com. ■

Drug prevents mother-to-child HIV infection

A study of 1,300 women who tested HIV-positive in labor or late pregnancy and who had not previously received and were not currently receiving other antiretroviral therapy for HIV found that a short dose of nevirapine was comparably effective to a longer dose of zidovudine plus lamivudine in preventing mother-to-child transmission of HIV.

Mother-infant pairs in the large multicenter study, conducted in South Africa where 60,000 infants are infected with HIV each year, were randomized to receive the nevirapine regimen or the zidovudine plus lamivudine regimen. Mothers in the nevirapine group received one dose of 200 mg nevirapine in labor followed by a second 200 mg dose 24 to 48 hours after delivery and a single 6 mg dose to their infants 24 to 48 hours after birth. Mothers in the zidovudine plus lamivudine group received zidovudine 600 mg, then 300 mg every three hours during labor and 300 mg twice daily for the next seven days, plus lamivudine 150 mg twice daily during labor and for the next seven days. Infants in the zidovudine plus lamivudine group received zidovudine 12 mg plus lamivudine 6 mg twice daily for seven days after birth.

Findings include:

- Overall rates of mother-to-child transmission of HIV were 14% in the nevirapine group, compared with 10.8% in the zidovudine plus lamivudine group.
- The rate of mother-to-child transmission was 6.3% for the nevirapine group, compared with 4.3% for the zidovudine plus lamivudine group.
- There were no treatment-related serious adverse events through six weeks in either group.

The most common side effects associated with

nevirapine are rash, fever, nausea, and headache.

Nevirapine is manufactured under the brand name Viramune by Boehringer Ingelheim Pharmaceuticals in Ingelheim, Germany. Researchers say they selected the drug for this study because of its ability to be stored at room temperature, an important consideration in developing countries. For details, visit the company's Web site at www.boehringer-ingelheim.com.

(Next month, Case Management Advisor *will provide information on the newest HIV treatment theories and case management strategies for improving patient adherence to antiretroviral therapies.)* ■

Disease management

NCQA announces plans to certify DM programs

The National Committee for Quality Assurance (NCQA) in Washington, DC, has announced it is actively developing a disease management (DM) certification program slated for 2001.

"More and more health plans are relying on disease management vendors to help improve their clinical performance and satisfy NCQA's standards," says NCQA president **Margaret E. O'Kane**. "Certifying disease management vendors will help health plans, employers, and others determine which vendors can help them meet their goals for quality, NCQA accreditation, and health improvement."

Over the past few years, many large employers have pressed for more effective management of workers' chronic conditions, such as diabetes and heart disease, and have even contracted directly with disease management firms, O'Kane says. While hundreds of DM programs exist, there is no formal mechanism of oversight for those programs or the organizations behind them, she adds. Many different types of organizations will be eligible to participate in the program, including DM vendors and the DM programs of managed care organizations.

For details, contact NCQA, 2000 L St., N.W., Suite 500, Washington, DC 20036. Telephone: (202) 955-3500. Fax: (202) 955-3599. Web site: www.ncqa.org. ■

Women who delivered before '92 run HCV risk

Coalition urges physicians to screen patients

Women who had cesareans, vaginal births, or other gynecological procedures that required a transfusion prior to 1992 are at risk for hepatitis C, according to the American College of Obstetricians and Gynecologists District IX in California and the California Hepatitis C Coalition in Sacramento.

"We are very concerned about women who received transfusions during gynecological procedures," says **Josephine L. Von Herzen**, MD, chair of District IX. "In addition, women who gave birth may not be aware that they had a transfusion of blood during the confusion and excitement of their procedure and the resulting birth of their child. A change in physician since that time could mean their new physician is not aware of the transfusion. We are sending reminders to physicians to double-check charts and discuss the risk factors with all patients," she says.

Hepatitis C virus (HCV) is spread by direct blood-to-blood contact. It was identified in 1989, but it was not possible to screen the blood supply effectively for HCV until 1992. As a result, the virus is widespread in the population, according to the California Hepatitis C Coalition.

In addition, HCV often has no symptoms. The most common symptom of HCV is extreme tiredness, according to the Centers for Disease Control and Prevention (CDC) in Atlanta. In addition, the CDC reports that it is possible to be infected for 20 years or more before significant liver damage takes place and recognizable symptoms begin.

"When patients come in for office visits, we urge OB/GYNs to review charts to make sure those who had transfusions before 1992 are tested for HCV," says **Jack Lewin**, MD, CEO of the California Medical Association in Sacramento and a Hepatitis C Coalition member. "It is urgent to identify any woman of childbearing age who may be infected. HCV can spread between the mother and unborn child."

Case managers who need more information can request the CDC's clinical recommendations on HCV by calling (800) 232-3228 or visiting www.cdc.gov/ncidod/diseases/hepatitis/resource/index.htm. ■

Oral solution effective alternative to injections

Many physicians rely on intramuscular (IM) injections of antipsychotic drugs to treat patients who need emergency room care for psychotic agitation. However, an oral solution form of risperidone is as effective and may be a more acceptable alternative to injections for both caregivers and patients, says a study presented at the annual meeting of the American Psychiatric Association held recently in Chicago.

The study found that oral solution risperidone works as quickly and effectively as IM injection of haloperidol. Both medications were administered in combination with the anti-anxiety drug lorazepam.

"When there are two drugs that are equally efficacious, a physician's next consideration when selecting an antipsychotic drug in emergency situations should be patient choice and compliance," says **Glenn Currier**, MD, lead investigator and assistant professor of the departments of psychiatry and emergency medicine at the University of Rochester (NY). "When patients experiencing psychotic agitation end up in the emergency room, they often are confused, scared, and paranoid. Injections are painful and can be perceived as hostile and coercive. This can be a significant barrier to the physician's ability to deliver good care and to the patient's ability to accept it," he says.

By contrast, he notes, an oral solution is more easily administered in emergency situations than pills or injections and is noninvasive. In addition, patients can continue on the same medication when they leave the hospital, which encourages long-term compliance. Further, injections expose staff members at hospitals and other facilities to an increased risk of needlesticks and a resulting exposure to diseases such as AIDS and hepatitis, especially when staff are interacting with agitated, sometimes violent patients, he adds.

Researchers studied 60 psychotic, agitated patients treated in the emergency room of a large, urban medical center. Patients were designated to receive either risperidone oral solution (2 mg) in combination with oral lorazepam (2 mg) or IM haloperidol (5 mg) with IM lorazepam (2 mg).

Researchers assessed the degree of agitation experienced by the patients — and the improvement demonstrated following treatment — using the Positive and Negative Syndrome Scale (PANSS) and Clinical Global Impression (CGI) scale. The agitation scores for patients in both groups were comparable at baseline and declined significantly in both groups at both 30 and 60 minutes following administration of medication.

Other findings include:

- PANSS scores dropped sharply in both groups from the 20 to 25 "extreme" range to the seven to 12 range within the first 30 minutes.
- PANSS scores in both groups dropped to the two to five range at 60 minutes.
- CGI ratings were evaluated at 15, 30, 60, and 120 minutes. On average, CGI scores for all

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Editorial Questions

Questions or comments? Call **Lee Reinauer** at (404) 262-5460.

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patients approached two, near the "very much improved" end of the scale, following medication.

• No adverse side effects were reported in the risperidone group, but one patient required IM haloperidol to manage continued agitation.

• One patient in the IM haloperidol group experienced acute dystonia.

Risperidone is manufactured under the brand name Risperdal by Janssen Pharmaceutica, a Belgian company with U.S. headquarters in Titusville, NJ. For details, click on the product information section of www.us.janssen.com. ■

Drug treats depression in psychotic patients

Depressive symptoms are common in patients with psychotic disorders and are associated with poor outcomes, increased risk of relapse, and high suicide rates. The atypical antipsychotic quetiapine fumarate appears to be effective in treating depressive symptoms in people with schizophrenia and other psychotic disorders, according to a study presented at the American Psychiatric Association annual meeting in Chicago.

"Depressive symptoms can interfere with people's ability to socialize, work, and function on a day-to-day basis," says study author **Martha Sajatovic**, MD, assistant professor of psychiatry at Case Western Reserve School of Medicine in Cleveland. "Our research shows that quetiapine fumarate can actually help people who suffer from schizophrenia and other psychotic disorders with their depressive symptoms, which I believe could help them participate more fully in society."

The study was a four-month, open-label trial involving 751 adults with psychoses. Patients were randomized to receive quetiapine fumarate or risperidone and assessed using the Hamilton Depression Scale (HAM-D), which evaluates the severity of 17 depressive symptoms reported during patient interviews. Both quetiapine fumarate and risperidone produced improvements in HAM-D scores. Quetiapine fumarate produced a statistically significant improvement of 44.6%, compared with 34.4% for risperidone, says Sajatovic. In addition, quetiapine fumarate produced a statistically greater effect in patients who scored high on the initial HAM-D test.

Quetiapine fumarate is manufactured under the brand name Seroquel by AstraZeneca with U.S. headquarters in Wilmington, DE. ■

CE objectives

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

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

Resource Bank™

A monthly compilation of news you can use from *Case Management Advisor*

JCAHO offers pain resource

Joint Commission Resources, a subsidiary of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in Oakbrook Terrace, IL, recently released *Pain Assessment and Management: An Organizational Approach.*

The publication provides an overview of the Joint Commission's new pain management standards, along with examples of implementation from organizations with successful pain assessment and management approaches. The book helps health care organizations identify and overcome barriers to pain assessment and management and anticipate how pain management will be integrated into JCAHO's performance measurement and survey process.

The book costs $35. Order code: PAM-100EM. Order by calling the Joint Commission customer service center at (630) 792-5800 between 8 a.m. and 5 p.m. CDT, Monday through Friday. Or, go to Infomart on the Joint Commission's Web site at www.jcaho.org. ▼

Software helps prepare for CCM

Busy case managers preparing to sit for the certified case manager (CCM) exam who can't take the time off work to attend a one- or two-day CCM preparation course may want to check out the CCMStep self-study program from Datachem in Westborough, MA.

The self-study program includes more than 600 questions with answers and referenced explanations. The interactive computer-based study program evaluates your knowledge in the six main subject areas covered on the CCM exam. The program simulates exams to gauge your readiness.

In addition, the software allows users to:

- recall previously missed questions;
- select weak areas via keyword searches;
- study at their own convenience.

The software is being offered at an introductory price of $229 plus $10 for regular shipping and handling, $25 for rush orders, and $35 for international orders. Residents of Massachusetts must add an additional 5% sales tax. Also, Datachem offers a site license for CCMStep for $999.

For more information, contact Datachem, 222 Turnpike Road, Westborough, MA 01581. Telephone: (800) 377-9717. Fax: (508) 366-5278. Web site: www.CertiStep.com. ▼

Forget painful allergy testing

Simple blood test offers safe option

A new, simple allergy blood test is now available for use by primary care physicians and pediatricians to diagnose allergy and causal allergens in the millions of Americans who suffer from allergy-like symptoms.

The Immuno-CAP Allergy Blood Test from Pharmacia & Upjohn Diagnostics in Kalamazoo, MI, is conducted in a laboratory, using a small sample of the patient's blood to determine if the patient's symptoms are being caused by allergens and, if so, which specific allergens.

For more information about ImmunoCAP, call (877) 862-4948 or visit the product Web site at www.isitallergy.com. ▼

Directory serves transplant community

Transplant Community 2000, the new membership directory for the United Network for Organ Sharing (UNOS) in Richmond, VA, contains nearly 200 more pages of data than the previous edition.

The 492-page directory includes tabs for quick searches, as well as center codes and lists of health organizations and individuals with ties to the transplant community. Every transplant center, organ procurement organization, and histocompatability laboratory will receive one complimentary copy. Additional copies are available for $99

for UNOS members and $195 for nonmembers plus a $6 shipping fee.

Copies can be ordered www.unos.org or by calling Marian Crow at (804) 330-8541. ▼

Web site offers support for epilepsy patients

The Epilepsy Foundation in Washington, DC, recently launched the Epilepsy Answer Place, a new Internet resource designed to answer questions about epilepsy for patients, their families, and health care professionals.

The Web site includes reliable information about seizures, first aid, research, and treatment to help people with epilepsy overcome barriers associated with the disorder. In addition, because seizure disorders can begin at any stage of life, enhanced search and navigation capabilities provide customized results for adults, parents, teachers, seniors, and others. Searches also can be sorted by topic, such as seizure recognition, safety, and surgery.

"People affected by epilepsy have almost as little knowledge about the condition as the general public," says **Martha Morrell**, MD, chair of the Epilepsy Foundation's board of directors. "Yet, the scientific understanding and treatment of epilepsy are advancing at a rapid pace. It is crucial that families and care providers have access to reliable, current information in order to manage seizures and cope with social factors that accompany them."

The Epilepsy Answer Place is an integral part of the foundation's Web site at www.epilepsyfoundation.org. ▼

Book examines leading cause of chronic disease

Obesity and an inactive lifestyle are two of the most prevalent risk factors for chronic disease. The important link between physical inactivity and obesity is addressed in *Physical Activity and Obesity,* recently released by Human Kinetics in Champaign, IL.

The book's authors present current, comprehensive discussion on the various aspects of physical activity and obesity. The book also provides the supporting data in table and diagram form. Its 19 chapters are organized into four sections:

• overview of the obesity epidemic and its implications for morbidity and mortality rates;

• determinants of obesity and assessments of energy expenditure and dietary habits;

• overview of the roles of physical activity and weight loss maintenance in the prevention and treatment of obesity for various population groups, including the severely obese;

• the role of physical activity in the comorbidities of obesity with respect to overall health status of the obese.

In addition, the last section of the book discusses how to safely modify the physical activity habits of the obese.

The 408-page book costs $49. ISBN#: 0-88011-909-8. For more details, contact Human Kinetics, 1607 N. Market St., P.O. Box 5076, Champaign, IL 61825-5076. Telephone: (800) 747-4457. Fax: (217) 351-1549. Web site: www.humankinetics.com. ▼

'Click' to improve compliance

Failure to follow a physician's advice may delay recovery from illness, increase medical costs, and heighten risk for certain conditions such as cardiovascular disease and stroke. The American Heart Association in Dallas recently launched a Web site with tools to improve patient compliance and reduce cardiac risk factors.

The new site, www.americanheart.org/CAP, is divided into two areas, one for consumers and one for health care professionals. The consumer area includes information and tips on better ways to follow physician advice about medications, diet, exercise, and how to quit smoking.

The professional area provides tools for physicians, case managers, nurses, and other members of the health care team to help patients comply with treatment recommendations. ■

Send us *Resource Bank* items

If you have a new resource, conference, or seminar of interest to other case managers, send items for publication to: Lauren Hoffmann, Editor, *Case Management Advisor,* P.O. Box 740056, Atlanta, GA 30374. Telephone: (770) 955-9252. Information on conferences and seminars must be received at least 12 weeks before the event to meet publication deadlines. ■