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# Case Management ADVISOR™

*Covering Case Management Across The Entire Care Continuum*

## IN THIS ISSUE



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Professional development

# Families must take the driver's seat in pediatric care management

*CM's job: Move caregivers toward independence*

Children are not miniature adults. Even children with temporary health issues may experience serious developmental delays, and because they cannot take ultimate responsibility for their own care, family participation is essential at every stage of the care management process. "If an adult enters the hospital for a month, or even two, with an acute illness or injury, he or she will still be able to walk and talk when discharged," says **Sharon Boyle**, RNC, BSN, CCM, program coordinator at The Coordinating Center for Home and Community Care, a nonprofit care management agency in Millersville, MD.

## Exclusive national survey on CM caseloads

American Health Consultants in Atlanta, publisher of *Case Management Advisor*, and the Case Management Society of America in Little Rock, AR, are collaborating on a unique survey that will, for the first time, shed light on national practices for setting and coordinating case management caseloads.

Case managers in both payer and provider settings will be surveyed as we compile a national database that explores pressing issues in setting and measuring case management caseloads across the care continuum.

Please take a moment to complete and fax the caseload survey inserted in this issue or complete the survey on-line at this address: www.ahcpub.com/CMcaseload.html. In return for your participation, you will receive, free of charge, an executive summary of the results of this national survey when they are released in the spring of 2001. ■

## Sticker shock: Inpatient costs soar

*Neonatal complications make top 10*

Did you know that in 1997, hospitals charged between $34,000 and $68,000 for the 10 most expensive conditions in inpatient fees alone, exclusive of physicians' and other professional fees, rehabilitation costs, or outpatient services?

The U.S. Agency for Healthcare Research and Quality (AHRQ) in Rockville, MD, recently released national statistics for the top 10 most expensive conditions treated in U.S. hospitals. Of those conditions, four are related to the care of infants with complications, two stem from trauma, and three involve the circulatory system. Leukemia and central nervous system infections also made AHRQ's top 10.

To download a reproducible chart of conditions with the highest mean charges and corresponding mean lengths of stay, visit http://www.ahrq.gov/news/press/pr2000/hospchart1.pdf. The chart is based on data from *Hospitalization in the United States, 1997.* An on-line edition of that AHRQ fact book is available at http://www.ahrq.gov/data/hcup/factbk1/. ■

"Even children who are developmentally on target experience developmental delays after even a brief hospitalization," she says. "Many of the children we work with are very medically complex and even technology dependent. Their needs continue throughout their lifetime. It requires a different approach to care management which requires the care manager to progressively move the family into assuming the role of care manager."

Boyle and co-worker **Carol Marsiglia**, RN, BSN, CCM, program coordinator for The Coordinating Center, reviewed standards of practice for case/care management and found they did an adequate job of establishing a minimum standard of care but did not begin to address the special needs of children with complex medical issues.

"We took all of the existing standards and looked closely at them — like trying to fit a puzzle within a frame," notes Marsiglia. "We found that they simply didn't address the full range of needs . . . of children who may be functionally dependent on a caregiver their entire lifetime with changing needs at each stage of development."

The case/care management standards that center staff reviewed, including those from the Case Management Society of America in Little Rock, AR, and the National Association of Social Workers in Washington, DC, did not address the need to intervene with children at risk to minimize or prevent developmental delays and health complications, she reports.

"We reviewed every national case/care management standard of practice currently available," Marsiglia says, "and then we developed our own pediatric care management pathway, which focuses on educating families and gradually reducing the family's dependence on the care manager to the point that the family moves into the care manager's role."

The desire to support the family in its role as care manager is central to every phase of The Coordinating Center's care management pathway. "When our program began, we, as professional care managers, took full responsibility for implementing and coordinating the plan of care," notes Boyle. Now, the family receives a copy of the care management pathway during the assessment phase, and right from the beginning we start the process of moving the family into the care manager's role."

Of course, not all families are ready to assume the role of care manager, agree Marsiglia and Boyle. "Families all begin in a different place in terms of the continuum of willingness and ability to assume care management responsibilities," Marsiglia explains. "Many are so overwhelmed by their child's current situation and medical needs that they simply can't take on another role. The pathway is designed so that the care manager helps the family move progressively toward independence. Timing is based on family readiness."

### *COMING IN FUTURE MONTHS*

- Setting CM caseloads: Results of exclusive national survey
- New approaches to breast cancer treatment
- New treatments improve function for RSD clients
- Pharmacy consults improve outcomes, reduce costs in chronic care
- Legal issues in workers' compensation

The Coordinating Center's care management pathway reflects this process of gently but continuously moving the family into the care manager's role beginning with the assessment phase, Boyle explains. Here is an outline of the eight-stage pathway:

**1. Assessment phase.** Service providers are identified. The family / primary caregiver recognizes the goal to assume the care manager role. Criteria are established for increasing community supports to decrease dependency on private service providers.

"Families receive a copy of the care management pathway at the first meeting with the care manager," says Boyle. "We carefully explain our role as partners with the family throughout this process."

## *Make sure home is safe*

In addition, the goal of pediatric care management for children with long-term complex needs is for care to take place in the home and community, which requires a careful assessment of the home environment for health and safety issues, notes Boyle.

"It's very important for the care manager to respect the family's culture and personal preferences during the assessment," she explains. "We focus only on those issues which may directly impact the health and safety of the child. If there are issues which may impact the child, we address them and find funding for [correcting them], if necessary."

For example, if the child has been sleeping on a mattress on the floor, it may seem inappropriate to the care manager, but it probably does not present a health or safety issue for the child. "We may discuss with the family ways to elevate the mattress to make caring for the child easier for nurses and other care providers, including family caregivers," says Marsiglia.

On the other hand, if the home of a child about to be discharged with a tracheostomy is infested with insects, it should be addressed because insects could crawl into the tracheostomy and place the child at risk. "For every issue we feel must be addressed, we focus the discussion on how it may affect the child's health," stresses Boyle. "If there's clutter everywhere in the home, we overlook it, unless the child is coming home from the hospital with a wheelchair. And, even then, we focus on simply clearing a path wide enough for the child to navigate through."

Access to care also is an essential health and safety consideration. "If the family does not have phone service, we ask them to think about how they will call 911 in case of a medical emergency," says Marsiglia. "One solution may be the purchase of a time-limited cell phone that's only used for emergencies."

Families also need to consider transportation. "What good is it to coordinate appointments if the family can't get the child to them?" asks Boyle. "We identify available transportation options and then support the family to make the necessary arrangements."

**2. Active care management.** The family / primary caregiver should be able to identify and access all service providers and describe each provider's role. "The goal of care management for children with long-term or lifetime needs is to keep the child in the community, and because there are limits on funding for professional caregivers, the family must be trained from the beginning to provide nursing care for the child and not rely too heavily on health care service providers," says Boyle.

"One of the goals of care managers from the beginning of care management is to make sure that family members understand and are trained for all of the child's daily medical needs, particularly because there may be a limit to nursing resources," she explains.

Sometimes, the care manager also must address this issue with professional nursing staff, adds Marsiglia. "Our goal is to promote family independence from professional service providers. Historically, nurses come in and take charge, and the family becomes dependent on the child's nurse," she says. "We find it's often necessary to go to the nursing agency and speak with the supervisor about educating their nurses about promoting this independence."

At this stage, care managers also stress with the family that at least two family members must be well-trained to provide the child's care. "We may be able to authorize 15 hours of nursing care, but if an ice storm hits, or the agency is understaffed due to a nursing shortage or a holiday weekend, the family must be able to care for the child," Marsiglia notes.

"It's the family's responsibility to provide a totally skilled backup caregiver if the agency can't fill all of the necessary nursing hours. Aunt Lola may need to be trained to relieve Mom; it's something we expect the family to decide and take responsibility for," she says.

**3. Week one.** The care manager reviews the plan of care with the family/caregiver. The primary caregiver actively implements care management tasks as negotiated with care manager.

Moving families into the care manager's role is a process that takes place over time, explains Boyle. "It's a process of negotiation between the care manager and the family. If there are 10 interventions which must be completed, the care manager helps the family identify them and then begins the process of negotiating which interventions the family will complete and which interventions the care manager will complete," she says.

Initially, the family may be able to manage only one intervention, but during the next phase of the pathway, it may be able to manage three, Boyle says. "There may be some back and forth over the course of care management. If the child is readmitted to the hospital or another family member becomes ill, the care manager may have to step back in and take on more responsibility until the situation stabilizes."

## *Consider all available resources*

It's also the care manager's responsibility to identify other care sources the family has tapped and provide only those skilled services that are necessary, Marsiglia says. "Between the family's church and the local high school, the child's nursing needs may already be met 24 hours a day. As care managers, we must always be aware of the cost of the plan. If the child's needs are adequately met without skilled nursing, we shouldn't approve it simply because we can."

Similarly, if the child needs nursing care during the school day, the care manager must identify whether there is a school nurse available to address those needs. "Each school district, each school, has different resources available. If there is a school nurse, we can save the resources allocated for nursing care," notes Marsiglia.

**4. Month one.** The primary caregiver initiates the reorder of supplies according to procedures established by the care manager and the durable medical equipment vendor. The primary caregiver participates in an educational, rehabilitative, or vocational program meeting and communicates with primary nurses and nursing supervisors.

Community resources are available for children that do not exist for adults, note Marsiglia and Boyle. "The care manager introduces the family to these resources and makes the necessary referrals and introductions and then trains the family to step into those education and rehabilitation systems — to attend the necessary meetings and oversee the child's progress," says Marsiglia. "Many communities have early intervention programs for children with developmental delays. The child's plan may be enhanced by accessing school-based speech or occupational therapy programs."

An essential part of training the family to move into the care manager's role is providing questions to ask service providers, notes Boyle. "If the child has the opportunity to attend a field trip with the school, we provide the family with the questions to ask about transportation and access. We train them to call ahead to the aquarium and find out about accessibility. If the child has access into the building but can't see more than half of the exhibits, it may not be appropriate for the child to go with the school on the field trip."

**5. Month two.** The primary caregiver communicates at least monthly with all service providers and participates in implementing educational, rehabilitative, or vocational goals.

**6. Month three.** The primary caregiver participates in a multidisciplinary team meeting to review the medical management goals and the plan of care.

Although The Coordinating Center does have contracts with other payers, most of the care managers' time is spent working with children in the Maryland Medicaid Waiver program. "We hold multidisciplinary meetings for each case at regular intervals to assess the current plan and make any necessary changes for the next six months to a year," explains Marsiglia.

"We invite all members of the team — the care manager, the family, the physician, the specialists, therapists, school representatives," she says. "They may not all come. At the least, the care manager, the physician, and the family must be present. Each team member identifies discipline-specific outcomes. The care manager is the primary liaison between the team members and the family and works to ensure that all of the outcomes are family-centered — it's the only way to be successful as a pediatric care manager."

When a care manager from The Coordinating Center works with managed care organizations, team meetings aren't mandated, but the care manager still tries to encourage them, adds Marsiglia. "The care management pathway is easily applied to any payer. We apply it now to any children we provide care management for, even those outside the Medicaid Waiver program."

**7. Month six.** The primary caregiver participates in a multidisciplinary team meeting to review medical management goals and the treatment plan at appropriate intervals.

**8. Professional care management termination.** The primary caregiver/family assumes the role of the care manager.

"The underlying philosophy for everything we do as pediatric care managers is to educate families in order to reduce their dependence on us as care managers," stresses Marsiglia. "The family is best suited to be the child's care manager. Our role is to integrate the responsibilities of the payer with family supports for care management." ■

# Management resources for pediatric care

Experienced pediatric care managers at The Coordinating Center in Millersville, MD, have developed several resources to help care managers and families integrate patients with complex needs into the community. With 35 to 40 children with complex needs on their active caseload, The Coordinating Center care managers are experts in dealing with this unique patient population.

To order any of the publications described here, mail or fax your request to The Coordinating Center, 8258 Veteran's Highway, Suite 13, Millersville, MD 21108. Fax: (410) 987-1685.

• ***The Coordination Pathway: A Family Centered Care Management Model for People with Complex Medical Care Needs in the Community.*** This easy-to-follow guide is based on desired outcomes for people with complex medical needs living at home. Cost: $25.

• ***Welcome Home: A Guide to Home Nursing Designed for Individuals, Families and Caregivers.*** This publication helps families and caregivers of people with special health care needs partner with nurses working in their homes and make the best use of the skills of these professionals. Cost: $10.

• ***Opening the Window on Managed Care: A Guide for People with Disabilities and Advocates.*** This guide teaches individuals and families how to navigate the managed care system. It provides families with processes and strategies to help obtain necessary care and services for individuals with complex medical needs. Cost: $15.

• ***Open the Door to People with Developmental Disabilities: A Guide to Disabilities for Managed Care Professionals.*** This guide provides key concepts as well as practical suggestions for providers interested in including people with disabilities. It is written for primary health care providers, health professionals, and administrators. Cost: $15.

In addition, *Opening the Window on Managed Care: A Guide for People with Disabilities and Advocates* and *Open the Door to People with Developmental Disabilities: A Guide to Disabilities for Managed Care Professionals* may be purchased as a set for $25.

• ***What's All the Fuss? A Guide for Child Welfare Professionals to Children with Special Health Care Needs.*** This resource is designed for anyone who works with families of children with complex medical care needs and who has an interest in the safety and nurturing of children with special needs in the community. Cost: $15. ■

# Future watch: Who will deliver care?

*Nation faces major nursing shortage*

It may be time for you to consider visiting a local high school on career day to tout the rewards of nursing as a profession. It also may be time for employers to recognize the growing need for and value of nurses and respond with increases in salaries. Why? Your future health and that of your clients may depend on it.

The nation's nurses are aging. That's no surprise. The problem is that young adults aren't entering the nursing field in large enough numbers to replace those nurses near retirement or to meet the health care demands caused by this large, graying nation.

Data from the U.S. Bureau of the Census' current population surveys show that the average age of RNs increased substantially from 1983 to 1998. Over the next 20 years, the trend will lead to continued aging of the RN work force with the largest groups of RNs between the ages of 50 and 69.

This supply shortage is expected to affect the access to and quality of health care in the United States as early as 2010. That's the year large numbers of nurses and the first of the nation's

## Look who's surfing now!

Nearly 80% of the nation's nurses now have Internet access, according to a recent survey conducted by *Nursing Spectrum* magazine in Chicago.

The survey of 3,000 RNs found that the number of nurses with Internet access has increased steadily from a low of 44% in 1997, to 54% in 1998, and 69% in 1999. Here are some other interesting findings about RN Internet use:

- 55% of RNs reported being on-line in the previous week.
- 22% of RNs reported daily Internet use.
- Nearly 25% of RNs reported using the Internet for employment information.
- 11% of RNs reported completing an Internet education course. ■

78 million baby boomers begin retiring and enrolling in the Medicare program.

What does this mean for employers, health care organizations, and consumers? Here are some findings from a recent evaluation of the aging RN work force published in the *Journal of the American Medical Association*:[1]

- The total number of full-time-equivalent RNs per capita is forecast to peak around the year 2007 and decline steadily thereafter as large groups of RNs retire.
- Within the next 10 years, the average age of RNs is forecast to be 45.4 years, an increase of 3.5 years over the current age, with more than 40% of the RN work force expected to be older than 50.
- The primary factor that has led to the aging of the RN work force appears to be the decline in the number of younger women choosing nursing as a career during the last 20 years.
- By the year 2020, the RN work force is forecast to be roughly the same size it is today, declining nearly 20% below projected RN work force needs for the population.

Researchers note that employers can expect average RN wages to rise as a result of the shortage. A growing trend to substitute RNs with other less-skilled personnel also may emerge.

### *Suggested reading*

1. Buerhaus PI, Staiger DO, Auerbach DI. Implications of an aging registered nurse work force. *JAMA* 2000; 283:2,948-2,954. ■

Disease management

# New drugs safer than steroids for Crohn's

Corticosteroids remain the leading therapy for Crohn's disease despite the risk of serious side effects, according to a nationwide survey recently released by Vanderbilt University in Nashville, TN.

"While steroids can be effective in controlling symptoms for the short term, physicians need to monitor patients' response to treatment carefully and evaluate their progress to minimize side effects, which can occur even after a brief period of time and be irreversible," explains **Charles A. Sninsky**, MD, associate director of gastroenterology, hepatology, and nutrition at Vanderbilt University Medical Center.

The national survey of more than 150 gastroenterologists and internists, each with a minimum of 10 Crohn's patients treated with corticosteroids, found that physicians continue to use steroids to treat Crohn's but are moving toward using alternative therapies. Findings include:

- 88% of physicians choose steroids to treat flare-ups in patients with severe cases.
- 75% of physicians choose steroids to treat moderate cases.
- 76% of physicians would keep patients on steroids for up to six months through an indefinite period to maintain remission.
- 19% would keep patients on steroids for 12 months.
- Overall, the average length of time physicians would use steroids to treat patients in remission is nine months.

Physicians reported continuing to prescribe steroids despite known side effects. Steroid-related side effects physicians reported noticing in their patients include:

- 36% of physicians reported their patients suffered weight gain.
- 21% reported fluid retention.
- 9% reported mood swings.
- 8% reported facial swelling.

Physicians recognized the potential long-term side effects of prolonged steroid use, including:

*(Continued on page 207)*

# Reports From the Field™

**Pulmonology**

## Investigational antibiotic zaps bronchitis

An investigational antibiotic, Factive (gemifloxacin mesylate), developed by SmithKline Beecham in Philadelphia, eradicated the bacterium H. influenzae after one day of treatment of airway infections in patients with chronic bronchitis, according to a study presented recently at the 40th Interscience Conference on Antimicrobial Agents and Chemotherapy in Toronto.

"Impressively, the bacteria were eradicated after just one day with just one dose of Factive," says **Thomas File**, MD, professor of internal medicine at Northeastern Ohio Universities College of Medicine and chief of infectious disease at Summa Health System in Akron, OH. "These results support the efficacy of five-day treatment of Factive compared to seven-day treatment with clarithromycin (Biaxin) in treating bacterial respiratory tract infections in patients with chronic bronchitis."

A double-blind, active-controlled study of 709 patients compared the efficacy of five-day treatment with gemifloxacin mesylate (320 mg once daily) to seven-day treatment with clarithromycin (500 mg twice daily) in patients with airway infections due to chronic bronchitis. For all patients with documented bacterial infections at study enrollment, the success rates at follow-up evaluation at week five were 81.8% with Factive vs. 62% with Biaxin.

In addition, researchers found that bacterial eradication occurred on day one of treatment following one dose of Factive, compared with evidence of H. influenzae in Biaxin patients through day seven.

"It is important to treat respiratory infections with an effective therapy that can eradicate bacteria quickly," says File. ▼

## Inhaled steroids don't stunt growth

Two major studies in the *New England Journal of Medicine* confirm that long-term use of inhaled corticosteroids to treat childhood asthma offers significant benefits in terms of asthma control with no long-term impact on growth.

Both studies examined the long-term effects of using an inhaled corticosteroid to treat childhood asthma. A study by Danish researchers examined the effect of long-term treatment with inhaled corticosteroid budesonide treatment on final adult height. Researchers found that, after a mean of 9.2 years of budesonide treatment at a mean daily dose of 412 mcg, children reached their target adult height to the same extent as their healthy siblings and the children in the control groups. No significant correlation was found between the duration of treatment or the cumulative dose of budesonide and the difference between the measured and target adult heights.

The second study involved more than 1,000 children between ages 5 and 12 years who had asthma symptoms for a mean of five years. After following the children for four to six years, the

American researchers not only confirmed the findings of their Danish peers but also concluded that an inhaled corticosteroid provided better asthma control than either placebo or nedocromil, a nonsteroidal anti-inflammatory.

Findings of this second study include:

- Compared with children in the placebo group, children taking the inhaled corticosteroid had a 43% lower rate of hospitalization, a 45% lower rate of visits for urgent care, and a 43% lower rate of prednisone use over the course of the treatment period.
- Children taking the inhaled corticosteroid had significantly fewer symptoms, used less albuterol, and had more days without asthma episodes.
- Children in the nedocromil and placebo treatment groups needed more belomethasone dipropionate and oral prednisone to keep their asthma under control.
- Children in the placebo group required additional medications on 18.7% of total treatment days.
- Children in the nedocromil group required additional medications on 17.1% of total treatment days.
- Children in the inhaled corticosteroid group only required additional medications on 6.6% of total treatment days.
- Children in the inhaled corticosteroid group experienced no decline in lung function over time, as did children in the other two groups.

"The results of these two studies reaffirm current guidelines regarding the use of inhaled corticosteroids as first-line maintenance treatment for children with persistent asthma," explains **Martha White**, MD, director of research at the Institute for Asthma and Allergy at the Washington Hospital Center in Washington, DC. "Inhaled corticosteroids are a key component of proper asthma management and have important benefits when used daily as a long-term preventive medication for persistent asthma, even mild persistent asthma."

[See: Agertoft L, Pederson S. Effect of long-term treatment with inhaled budesonide on adult height in children with asthma. *N Engl J Med* 2000; 343:1,064-1,069. See, also: The Childhood Asthma Management Program Research Group. Long-term effects of budesonide or nedocromil in children with asthma. *N Engl J Med* 2000; 343:1,054-1,063.] ■

**HIV/AIDS**

## Once-daily drug fights HIV

French researchers presented one-year results of a pilot study indicating that a once-a-day HAART (highly active antiretroviral therapy) regimen combining emtricitabine, didanosine, and efavirenz as a first-line therapy in treatment-naive HIV-infected patients was well-tolerated and effective.

Speaking at the 38th Annual Meeting of the Infectious Disease Society of America in New Orleans, researchers reported that at 48 weeks, 95% of patients on the regimen had a viral load below 400 copies / mL.

"The results showed that the once-daily HAART regimen containing Coviracil (emtricitabine) was generally well-tolerated and demonstrated strong antiviral and immunologic effects lasting for the 48-week duration of the study," notes **Franck S. Rousseau**, MD, executive vice president of medical affairs and chief medical officer of Triangle Pharmaceuticals in Durham, NC, developers of Coviracil. "In fact, 95% of patients maintained plasma HIV RNA levels below 400 copies / mL through 48 weeks, showing that the long-term potency of this once-a-day regimen is very impressive," he says.

"The durability of this regimen to successfully suppress viral load over a 48-week period is very encouraging," adds **Jean-Michel Molina**, MD, one of the French researchers from the Centre de Recherche sur le SIDA outside Paris. "Patient adherence is emerging as a major challenge as HIV treatment regimens become more complicated. Once-a-day dosing might improve patient adherence that we know is correlated to better virologic suppression."

The 48-week open-label pilot study was designed to examine the antiviral activity and safety of a once-a-day HAART regimen. Forty HIV-infected patients received once-daily doses of Coviracil (200 mg), didanosine (400 mg for patients 60 kg or more in weight and 250 mg for patients under 60 kg), and efavirenz (600 mg). The patients had median baseline HIV RNA levels of 4.77 $\log_{10}$ copies / mL and median baseline CD4 counts of 373 cells / $mm^3$. At 48 weeks, CD4 count increased by a median of 159 and 205 cells / $mm^3$. ■

## Oncology

# Cancer drugs shrink tumors

Two investigational cancer drugs not only may limit the growth of existing tumors but also may prevent cancer development in high-risk patients with breast and colorectal cancer, according to data presented at the Congress of the European Society for Medical Oncology in Hamburg, Germany.

**Hormone inactivator for breast cancer**

Early results from a phase II study found that exemestane tablets, an oral aromatase inactivator being studied as a first-line treatment for breast cancer, were more than 20% more effective than tamoxifen for treating advanced breast cancer. In the objective response rate, a measurement of how the tumor optimally reacts to the treatment, patients in the exemestane group experienced a 42% objective response rate, compared with 16% for the tamoxifen group. In addition, average time of tumor growth and spread was slower in the exemestane group at 8.9 months, compared with 5.9 months for the tamoxifen group.

The drug is the first in a new class of oral hormonal inactivator therapies. It binds with the aromatase enzyme and prevents it from producing estrogen, which some breast cancers need for growth.

Results from a recently completed phase II study of the drug in breast cancer patients before surgery also were presented. Exemestane was provided to patients in an effort to shrink large primary breast cancers before surgical removal. In a sample of 13 postmenopausal women with estrogen receptor-positive breast cancer, exemestane resulted in a median tumor volume reduction of 83% over the course of three months as assessed by ultrasound.

**Drug prevents vessel growth**

Clinical studies of SU5416, a synthetic small molecule inhibitor, indicate the drug reduces tumors in patients with colorectal cancer by as much as 50%. SU5416 works by inhibiting the growth of new blood vessels that cancerous tumors use to provide nutrients and oxygen essential for their growth, causing tumors to slow or halt growth.

In a phase I/II study of 27 patients treated with SU5416 in combination with 5-FU/leucovorin, 37% of patients had a complete or partial response to treatment, with tumor reduction of greater than 50% of original size. More than 40% of patients had stable disease, meaning tumors had neither grown nor reduced in size. Only 7% of patients showed no response to the treatment. ■

## Neurology

# Drug works better for elderly epileptics

Data pooled from more than 13 studies indicate that in elderly patients, lamotrigine is better tolerated than carbamazepine for treatment of epilepsy.

Roughly 25% of all new cases of epilepsy occur in people over age 60. Many physicians face a difficult choice when prescribing first-line anti-epileptic drugs for these older patients. Age-related changes in metabolism and the likelihood of patients receiving multiple medications for concurrent conditions make the choice of a drug treatment for epilepsy particularly hazardous. Also, elderly people, with generally slower metabolisms, are considerably more sensitive to drug side effects than younger people.

### *Fewer patients quit treatment*

Lamotrigine, which can be prescribed as an add-on or monotherapy in adults with epilepsy, has a desirable pharmacological profile for use in the elderly, according to data presented at the Fourth European Congress on Epileptology in Florence, Italy. Lamotrigene has a long elimination half-life, is effective in all common seizure types, does not inhibit or induce hepatic metabolism, and does not cause central nervous system side effects such as drowsiness, confusion, or cognitive impairment, researchers note.

"We have shown conclusively that lamotrigine is both safe and well-tolerated in elderly patients, and these studies have shown that individuals treated with lamotrigine are twice as likely to continue treatment than patients who receive older anti-epileptic drugs such as carbamazepine," says

**Luigi Giorgi**, MD, principal clinical research physician for Glaxo Wellcome in Research Triangle Park, NC. "Lamotrigine is a highly effective, safe, and well-tolerated drug for younger adults and the elderly alike."

The pooled data included 199 elderly patients and 596 adult patients under age 65 with newly diagnosed epilepsy receiving either lamotrigine or carbamazepine as a monotherapy. Both drugs were found to be highly effective in terms of seizure prevention, but lamotrigine was associated with significantly fewer adverse events than carbamazepine, and the incidence of drowsiness was approximately halved in the lamotrigine treatment group compared with the carbamazepine group. In addition, very few people withdrew from treatment with lamotrigine, whereas up to 42% of patients withdrew from carbamazepine treatment due to adverse events. ■

**Behavioral health**

# Drug improves cognitive function

A study presented at the 13th European College of Neuropsychopharmacology Conference in Munich, Germany, holds out new hope for patients experiencing symptoms of psychosis. Researchers presented evidence from two recent clinical studies that suggest treatment with the atypical antipsychotic Seroquel (quetiapine fumarate) significantly improved cognitive function in patients with chronic schizophrenia or Parkinson's disease who experience symptoms of psychosis.

A six-month, open-label study compared cognition in 29 Parkinson's patients experiencing psychotic symptoms treated with Seroquel to baseline and to 12 nonpsychotic patients who were not treated with Seroquel. Researchers assessed cognitive function before and after six months of Seroquel therapy.

Patients with Parkinson's disease experiencing psychotic symptoms who received treatment experienced significant improvement in their ability to remember information and remain attentive compared to baseline, while the control group exhibited no change in delay story recall and significant decline in sustained attention.

"Psychosis is a mental disorder that impairs a person's ability to recognize reality, communicate, and relate to others," says study researcher **Jorge L. Juncos**, MD, of the Emory University School of Medicine in Atlanta.

"Seroquel has been shown to effectively treat the psychotic symptoms without impairment of a person's ability to interact with the outside world. This study shows Seroquel may benefit some Parkinson's patients experiencing psychotic symptoms by strengthening their capacity to function in society," he says.

## *Test scores improve*

In a study of Seroquel in 58 patients with chronic schizophrenia, those patients receiving the drug had significant improvement compared with patients receiving haloperidol in an number of aspects of cognitive function, including organization and planning, movement control, learning, and memory.

Cognitive performance on standardized verbal and memory recall tests improved more in patients receiving Seroquel therapy 600 mg per day than for patients receiving Seroquel 300 mg a day or patients receiving haloperidol 12 mg per day.

In a second study involving 25 patients, significant improvements in measures of executive and motor function, learning, and memory were experienced by the Seroquel group, whereas the haloperidol group exhibited improvements only in visuomotor tracking with alteration and story recall.

Seroquel is manufactured by AstraZeneca in Wilmington, DE. Full prescribing information is available on-line at www.seroquel.com.

[See: Juncos JL, Jewart RD, et al. Tolerability, efficacy and cognitive effects of quetiapine in patients with Parkinson's disease treated for psychotic symptoms. Poster presented at the 13th European College of Neuropsychopharmacology Conference. Munich, Germany; September 11-13, 2000.

Hellewell JSE. The effect of quetiapine in improving cognitive impairment in schizophrenia. Poster presented at the 13th European College of Neuropsychopharmacology Conference. Munich, Germany; September 11-13, 2000.] ■

(Continued from page 202)

• 55% of physicians identified osteoporosis as a potential long-term effect.
• 29% identified cataracts.
• 27% identified high blood pressure.

"The bottom line is that steroids are generally not effective for the extended maintenance of Crohn's disease, and, therefore, alternative therapies should be explored," says Sninsky.

Although 65% of physicians surveyed continue to rely on steroids because of their fast onset of pain relief, the survey also identified a growing move toward alternative therapies, including:

• 29% of physicians reported prescribing infliximab to treat severe Crohn's flare-ups.
• 59% of physicians reported prescribing 5-ASA drugs for moderate cases of Crohn's, and 20% report prescribing the drug for severe cases.
• 8% of physicians reported prescribing 6-mercaptopurine for moderate cases of Crohn's, and 8% report prescribing it for severe cases.
• 30% of physicians reported believing that some Crohn's patients can never be taken off steroids.

"Our major concern is a flare-up of Crohn's symptoms when steroids are reduced. However, some of the symptoms that patients experience as they withdraw from steroids, like fatigue and joint pain, are due in part to the steroid use itself and a resulting adrenal insufficiency. These symptoms can decrease as patients are tapered off steroids. More important, these and other symptoms associated with steroid use can be avoided by alternative therapies," Sninsky says.

"The good news for all Crohn's patients is there are newer, safer, and well-tolerated medications available, like infliximab, that are emerging as proven treatment options that not only provide quick relief of symptoms without the side effects of steroids, but also help in healing the intestines," he notes. "In recent studies, we've seen that patients who receive infliximab are able to stop or greatly reduce their use of steroids."

Treatment with infliximab also greatly reduces patients' need for other medical services, according to a study presented at the American College of Gastroenterology annual meeting in New York City. Researchers reviewed electronic medical records and charts and assessed the use of inpatient and outpatient medical services at the University of Chicago Medical Center from three years prior to infliximab treatment to one year following infliximab treatment.

Patients treated with infliximab experienced the following results:

• 38% decrease in overall annual incidence of all surgeries;
• 43% decrease in endoscopies;
• 66% decrease in patient visits to the emergency room;
• 16% decrease in all outpatient visits;
• 20% decrease in outpatient gastrointestinal visits;
• 12% decrease in radiology exams.

Some patients with Crohn's disease develop fistulas that burrow through the bowel wall into nearby organs or through the surface of the skin. When looking specifically at the subset of Crohn's patients with fistulas, researchers found that infliximab treatment showed similar reductions in overall medical services.

Specific findings include:

• 59% decrease in hospitalizations;
• 66% decrease in surgeries;
• 64% decrease in emergency room visits;
• 27% decrease in outpatient visits;
• 40% decrease in radiology exams.

"Given the high costs associated with surgery and hospitalization, the use of infliximab may translate to an overall savings for these patients and the health care system," says **Russell D. Cohen**, MD, assistant professor of clinical medicine and co-director for clinical inflammatory bowel disease at the University of Chicago Medical Center. ■

# Nerve stimulation system reduces epileptic seizures

*Results improve over time*

A new treatment option holds great promise for patients with refractory epilepsy who have not successfully controlled their seizures with available medications. The largest prospective long-term study to date of vagus nerve stimulation (VNS) indicates that it is not only an effective long-term treatment for reducing seizure frequency in patients with refractory epilepsy but that it actually increases in effectiveness over time.

Researchers lead by Christopher DeGiorgio, MD, professor of neurology at the University of California, Los Angeles, followed 195 patients over a 15-month period. The study, recently

published in the journal *Epilepsia,*[1] consisted of an initial three-month randomized and double-blind phase during which patients received a high or active level of stimulation.

At the conclusion of the double-blind phase of the study, results included:

- The median reduction in seizure frequency was 34%.
- After 12 months of stimulation, the participant median seizure reduction increased to 45%.
- 20% of patients involved in the study sustained a greater than 75% reduction in seizure occurrence at 12 months.

"This is the largest long-term prospective study of vagus nerve stimulation ever published," says DeGiorgio. "It shows that the effectiveness of VNS, modest after three months, is substantially improved after one year of long-term follow-up. Twenty percent of patients sustained a 75% to 100% reduction in seizures, increased from only 11% at three months. The median reduction was a very robust 45%. The population chosen had extremely severe epilepsy and had failed multiple medications in the past. VNS does not cause all the drug side effects that medicines cause."

VNS was delivered by the NeuroCybernetic Prosthesis (NCP) System developed by Cyberonics in Houston. Often called the "pacemaker of the brain," the system consists of a pocket watch generator implanted under the skin in a patient's chest. A lead wire from the device is tunneled up the neck, and coils at the end of the wire are wrapped around the vagus nerve in the neck. Using a laptop computer and a programming wand, the neurologist programs the NCP System to deliver regular, mild electrical stimulation to the vagus nerve.

The system has been clinically proven to decrease, and in some patients, completely eliminate, seizures by conditioning the brain to react better to the interruptions in the brain function common in epilepsy. In addition, patients may pass a magnet over the device when they sense a seizure coming for an extra dose of stimulation to decrease the severity or stop a seizure in its tracks.

### Reference

1. DeGiorgio CM, Schacter SC, Handforth A, et al. Prospective long-term study of vagus nerve stimulation for the treatment of refractory seizures. *Epilepsia* 2000; 41:1,195-1,200. ■

# New FDA Approvals

The following drugs recently received approval from the U.S. Food and Drug Administration in Rockville, MD.

✔ **Camptosar for colorectal cancer:** Pharmacia in Peapack, NJ, has received approval for Camptosar (irinotecan hydrochloride injection) as first-line therapy for the treatment of patients with metastatic colorectal cancer in combination with 5-fluorouracil/leucovorin (5-FU/LV).

The FDA approval is based on data from two phase III studies which demonstrated the potential of Camptosar to prolong patients' lives when used in combination with 5-FU/LV as a first-line treatment for metastatic colorectal cancer, compared with 5-FU/LV alone. Those studies, conducted primarily in North America and Europe, demonstrated prolonged median survival and significantly longer time to tumor progression for the regimen of Camptosar and 5-FU/LV, compared with 5-FU/LV alone.

For patient product information, call (888) 691-6813.

✔ **Novantrone reduces MS-related disability:** Immunex in Seattle has been approved for Novantrone (mitoxantrone for injection concentrate) as the first therapy approved for secondary-progressive multiple sclerosis (MS). Novantrone is indicated for reducing neurologic disability and/or the frequency of clinical relapses in patients with secondary-progressive, progressive-relapsing, or worsening relapsing-remitting MS.

FDA approval is based on results from a 24-month phase III clinical trial in which Novantrone 12 mg/$m^2$ was administered by short infusion once every three months. This trial demonstrated that it had a statistically significant impact on prolonging time to first-treated relapse and on delaying disability progression in patients with secondary-progressive or progressive-relapsing MS.

Patients in the Novantrone group experienced a significant reduction in the mean number of treated relapses. They also experienced a significant reduction in new MS lesions seen on magnetic resonance imaging. Patients taking the drug may develop serious heart problems. To measure potential heart changes, patients should receive regular testing of their heart's ability to pump

blood. In addition, due to risk of heart injury, there is a limit to the total lifetime amount of Novantrone a patient should receive. For most patients, the lifetime total is roughly eight to 12 doses over two to three years.

For more details, visit www.novantrone.com or www.immunex.com or receive full prescribing information by calling (800) 566-8268. ■

Long-term care/geriatrics

# HCFA panel gives InterStim thumbs up

*HCFA will rule on coverage before end of year*

Nearly 17 million Americans suffer from urinary incontinence, and this embarrassing and sometimes disabling condition often is the trigger that moves older patients out of their homes and into nursing homes. Now, an implantable treatment that provides excellent urinary control may receive Medicare coverage before the end of the year and prevent many premature nursing home admissions.

The InterStim Therapy for urinary control developed by Minneapolis-based Medtronic recently received a unanimous thumbs-up from the Medical and Surgical Procedures Panel of the Health Care Financing Administration's Medicare Coverage Advisory Committee in Baltimore. That approval is likely to result in a national Medicare coverage policy for sacral nerve stimulation.

The panel affirmed the effectiveness of the InterStim Therapy, which uses sacral nerve stimulation to treat patients with refractory urinary urge incontinence and urgency-frequency. The device is indicated for the treatment of urinary urge incontinence, nonobstructive urinary retention, and significant symptoms of urgency-frequency when drugs prove inadequate or cause intolerable side effects.

In InterStim therapy, an implantable neurostimulator delivers mild electrical stimulation to the sacral nerves, which are located in the lower back and influence bladder function.

In a clinical study, InterStim showed sustained clinical benefit in implanted patients. At the 12-month follow-up exam, researchers found:

- 73% of patients with urinary urge incontinence achieved a reduction in leaking episodes per day of 50% of more.
- 55% of patients with urgency-frequency experienced an increase in volume eliminated per void of 50% or more.
- There were no reports of permanent injury associated with the devices or use of sacral nerve stimulation.
- Roughly 30% of patients who received InterStim underwent subsequent surgery to reposition or replace elements of their systems.

InterStim Therapy costs about $10,000, including the neurostimulator and lead. Physician and hospital fees vary regionally but range between $15,000 and $20,000. ■

# Free kit helps prevent stroke

*Too few patients receive preventive care*

Atrial fibrillation (AF) causes 80,000 strokes each year in the United States. National results on hospital performance for proper stroke prevention care in Medicare patients are dismal, according to a recent *Journal of the American Medical Association* article.

But the National Coalition for Stroke Prevention Awareness (NCSPA) in Lisle, IL, is working to improve the nation's record on caring for those at-risk for stroke, and case managers can play a vital role by putting NCSPA's stroke education tools in the hands of physicians caring for their clients with AF.

"Through the use of our quality enhancement tools, physicians across the country have improved the number of patients receiving the best measures to prevent stroke," notes **Melba Moore**, executive director of NCSPA. In fact, NCSPA has found that in Illinois, where its Atrial Fibrillation Prevention Guide (AFP) and Tool Box are in use, proper treatment of AF has improved from 55% to 67% in the past two years.

AF is the most common persistent cardiac arrhythmia, affecting more than 2 million Americans. The AFP guide to preventing strokes and lowering health risks in AF patients includes a quick reference for physicians with consensus recommendations for patients who are at risk for stroke.

"The quick reference guide can easily be placed in the charts of patients who are identified as being at risk for stroke so that physicians can be sure to address the issues when meeting with the patient," says **Bruce Steffens**, MD, a family physician in Illinois who helped develop the AFP guide.

A national study of Medicare fee-for-service beneficiaries found that nearly half left the hospital without proper medications and follow-up instructions.[1] "The *JAMA* article indicates that too many patients are leaving the hospital without optimal stroke prevention therapy," says Moore. "We are hopeful that NCSPA's outreach efforts with our AFP Guide and Tool Box can bring future improvement to every state."

The tool box helps health care organizations evaluate the progress of their providers in screening all patients for stroke risk. Moore says the tool box is easily adapted to design an appropriate continuous quality improvement process to bring optimal stroke prevention to each patient at risk in any health care organization.

The tool box can be downloaded at no charge by visiting www.ncspausa.org.

### Reference

1. Jencks SF, Cuerdon T, Burwen DR, et al. Quality of medical care delivered to Medicare beneficiaries. *JAMA* 2000; 284:1,670-1,676. ■

Behavioral health

# Patients want PCPs to treat depression

*Yet, study finds few achieve full recovery*

Twice as many people first turn to their primary care physician (PCP) for help with depression and general anxiety disorder (GAD) than to a psychiatrist, according to a survey by the National Mental Health Association (NMHA) in Alexandria, VA. Unfortunately, although PCPs have made great strides in recognizing and treating these mental health disorders, few patients report reaching a full recovery.

The NMHA survey clarifies that patients want their PCPs involved in depression treatment. "More than 70% of patients surveyed wanted their primary care physicians more involved in their depression care," says **Jeremy Kisch**, PhD, a clinical psychologist and senior director of clinical education at NMHA.

"In most cases, patients have seen their primary care physicians for years and have established a level of comfort and trust with them," explains **Michael Faenza**, president and chief executive officer of NMHA. "Thus, they want their physicians to be more involved in detecting depression and GAD and in helping them recover so they can return to previously enjoyed activities."

The NMHA survey included more than 3,200 adults over age 18. Participants were interviewed by telephone about their awareness and understanding of clinical depression and GAD as well as their awareness of available treatments and expectations of the results of treatment. A total of 1,495 interviews were conducted in more depth. Of those, 980 participants had experienced depression or GAD, and 515 had not.

The survey revealed that PCPs are at the front line for diagnosing and treating mental illness and are having some success. Findings include:

- Among patients diagnosed with clinical depression, 42% were diagnosed first by their PCP, compared with 34% by a psychiatrist.
- Among patients diagnosed with GAD, 47% were diagnosed first by their PCP, compared with 31% by a psychiatrist.
- Among patients with clinical depression, 47% gave their treatment a grade of "A" in terms of enabling them to fully carry out daily responsibilities.
- Among patients with GAD, 44% gave their treatment an "A" in terms of enabling them to fully carry out daily responsibilities.
- Only 28% of patients with clinical depression and 32% of patients with GAD gave their treatment an "A" for returning them to previously enjoyed activities.

Kisch notes that far too few patients reported achieving full recovery. "The ability to carry out daily responsibilities is not the same as a full recovery. The field is beginning to differentiate and understand that there is a difference between relief from symptoms and a return to full quality of life," he explains.

The NMHA survey results support that statement. Consider the following findings:

- Only 36% of patients with clinical depression and 21% of patients with GAD reported reaching full recovery.

• Slightly more than 50% of patients with clinical depression and 56% of patients with GAD reported a limited recovery.

• The remaining 11% of patients with clinical depression and 23% of patients with GAD reported no recovery at all.

• Patients who saw their PCP first had higher recovery expectations than patients who saw a psychiatrist first. In fact, 50% of patients first seen by their PCP expected a full recovery, compared with 40% of patients who first saw a psychiatrist.

The survey also revealed important clues and uncovers some troubling findings about how to achieve full recovery from clinical depression and GAD. Among those clues are:

• The majority of patients treated for clinical depression reported difficulty coping with the side effects of medication and often had to change medication.

• More than 50% of patients sampled asked their physicians to switch them to other medications. Efficacy was cited as the reason for medication change by 30% of patients, and side effects were cited as the reason by 50% of patients.

• Despite difficulties with medication, 76% of those diagnosed with clinical depression reported believing that antidepressants were as effective as antibiotics.

• Even when symptoms improved, many patients experienced only partial recovery.

• Few patients take medication alone for either clinical depression or GAD. More than 60% of patients with depression reported being treated with a combination of medication and psychotherapy, and only 20% took medication only.

• Nearly 40% of patients with clinical depression reported noticing recovery within a few weeks.

• Nearly 70% of patients with clinical depression reported improvement within two months. That figure rose to 89% after two months.

• Only 6% of patients with clinical depression reported no improvement.

• Roughly 30% of patients with GAD experienced progress within a few weeks.

• About 50% of patients with GAD reported improvement within one month. That figure rose to 62% within two months and 78% after two months.

• Only 10% reported no improvement, while 13% reported not knowing how long it took them to first notice improvement.

• More than 30% of patients with GAD were treated with medication only.

Kisch says the vast majority of patients in the NMHA study participated in some form of talk therapy. "Studies in the literature support the finding of the NMHA study that patients treated with a combination of antidepressants and psychotherapy often achieve fuller recovery from depression than patients receiving either therapy alone," he says. "For example, a study of 681 patients with depression reported in the *New England Journal of Medicine*[1] found that 85% of patients receiving a combination of nefazodone and psychotherapy responded to treatment, compared to 55% of patients receiving nefazodone alone and 52% receiving psychotherapy alone.

"An editorial in that same issue[2] identifies that there is still a strong need to develop a more effective therapeutic approach to effective depression

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## Editorial Questions

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

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treatment in general clinical settings," says Kisch. "The whole issue of how to move from a partial to full recovery has also not yet been well-identified."

Kisch says other recent studies suggest that case managers have a role to play in improving depression outcomes. "A study of depression outcomes in a managed primary care setting reported in the *Journal of the American Medical Association*[3] found patients and providers who received counseling and education from specially trained social workers and nurses achieved better outcomes," he notes. In fact, 50.9% of patients who received counseling and education responded well to treatment, compared with 39.7% of patients who didn't receive these interventions. "It's an improvement. It's not good enough, but it's an improvement."

Which components of a treatment plan contribute to full recovery from clinical depression still must be better identified, he stresses. "How much difference does it make to participate in a quality improvement [QI] process which includes nursing or social work interventions? Would a better QI process lead to better results, or is the difference in cost not justified? Does every patient with clinical depression require psychotherapy plus medication, or do some do just as well with medication alone? We simply don't have the evidence we need."

The findings, Kisch says, should motivate health plans to use less costly providers such as nurses and social workers to support patients during treatment of depression and GAD. "There's no hard evidence, but there is a strong sense that patients who want more primary care involvement are reaching for more support and help. This can be provided by social workers and nurses working with the physician."

The road to recovery may be difficult, he says. "Along that road, PCPs play a valuable role in both identifying individuals who need treatment and often providing that treatment themselves. The key is for some provider to be in a position to make a diagnosis, and most often that is a PCP."

### *References*


1. Keller MB, McCullough JP, Klein DN, et al. A comparison of nefazodone, the cognitive behavioral analysis system of psychotherapy and their combination for the treatment of chronic depression" *N Engl J Med* 2000; 342:1,462-1,470.

2. Scott J. Editorial: Treatment of chronic depression. *N Engl J Med* 2000; 342:1,518.

3. Wells KB, Sherbourne C, Schoenbaum M, et al. Impact of disseminating quality improvement programs for depression in managed primary care. *JAMA* 2000; 283:212-220. ■




## 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™

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## Toolbox offers drug treatment info

The National Institute on Drug Abuse (NIDA) in Washington, DC, has compiled years of drug abuse and addiction research into a toolbox for drug abuse counselors.

The free toolbox is packaged in a magazine file box large enough to store all current NIDA drug treatment publications as well as additional reports as they are developed. The box contains:

- three therapy manuals on treatment of cocaine addiction, which highlight the cognitive-behavioral, community reinforcement plus vouchers, and individual counseling approaches;
- approaches to drug abuse counseling;
- principles of drug addiction treatment, a research-based guide;
- NIDA research reports on anabolic steroids, cocaine, heroin, inhalants, nicotine, and methamphetamine;
- NIDA publications catalog;
- commonly abused drug chart.

The materials included in the kit are available on-line at www.drugabuse.gov. Ordering information for the toolbox is available by calling the Clearinghouse for Drug and Alcohol Information at (800) 729-6686. ▼

## Resource focuses on pediatric mental health

A monograph and a reprint of a brief on children's mental health issues are now available at no charge from the Agency for Healthcare Research and Quality (AHRQ) in Rockville, MD. The materials were developed by the Children's Mental Health Alliance Project, supported by in part by AHRQ and led by Annie G. Steinberg, MD, of the Children's Mental Health Practice and Research at the University of Pennsylvania and the Children's Hospital of Pennsylvania.

The monograph includes:

- a review of evidence-based, best-practices approach to the primary care / specialty care relationship as it applies to pediatric mental health;
- a discussion of the underrecognition of the mental health problems that affect children and adolescents and the poor outcomes that often occur in pediatric mental health;
- clarification of the professional responsibilities across systems of care to avoid duplication, address shortages, and define health services research priorities;
- a series of recommendations for pediatric mental health services research topics.

Copies of the monograph, *Children's Mental Health: The Changing Interface Between Primary and Specialty Care* (AHRQ Publication # 00-R040) are available from the AHRQ Publications Clearinghouse at www.ahrq.gov.

### *Briefly speaking*

The reprint, an issue brief published by the University of Pennsylvania's Leonard Davis Institute of Health Economics, was written by Steinberg and colleagues. It briefly summarizes, in bullet form, much of the information in the monograph described above, including the following:

- changes in children's mental health ervices over the past decade;
- increases in psychotropic drug use in children;
- effects of managed care on the delivery of mental health services to children;
- resources needed by primary care providers to identify and address children's mental health needs;
- a system-of-care model.

The issue brief also is available from the AHRQ Publications Clearinghouse. ▼

## Study needs women for cancer research

The National Surgical Adjuvant Breast and Bowel Project (NSABP), a nonprofit clinical trials cooperative group, recently launched a phase III clinical trial to evaluate Herceptin (trastuzumab), manufactured by Genentech in South San Francisco, CA. More than 100 sites in the United States and Canada are participating in the study to assess the safety and efficacy of the combination of Herceptin and chemotherapy in the treatment of 2,700 node-positive breast cancer patients whose tumors overexpress the human epidermal growth factor receptor-2 (HER2) protein or demonstrate evidence of HER2 gene amplification.

Herceptin, a humanized monoclonal antibody, was approved by the Food and Drug Administration in Rockville, MD, to treat women with metastatic breast cancer whose tumors are known to have an overexpression of HER2. Previous research has proven the drug's ability to target the HER2 receptor in metastatic breast cancer that decreases the spread of the disease and prolongs patient survival. One study found that women with HER2 positive metastatic cancer who received Herceptin in combination with chemotherapy lived longer than those who received chemotherapy alone.

NSABP Protocol B-31 will be conducted in two stages. The first stage will evaluate 1,000 patients for cardiac safety and compare the toxicities of adding weekly Herceptin to adjuvant Taxol following Adriamycin and cyclophosphamide.

If researchers determine that the potential benefits of Herceptin therapy are greater than the drug-related side effects, the study will proceed to the second stage. The second stage will include an additional 1,700 patients to study the efficacy of adding Herceptin to the standard chemotherapy regimen of cyclophosphamide followed by Taxol in prolonging patient survival and disease-free survival.

Women will be enrolled in the study over five years. To participate, a woman must meet the following criteria:

- operable breast cancer treated with lumpectomy plus irradiation or mastectomy;
- histologically positive axillary nodes;
- breast cancer with strong HER2 protein overexpression determined either by immunohistochemistry or HER2 amplification by fluorescent in situ hybridization;
- no evidence of metastatic disease;
- no existing heart disease.

For more details, or to locate a participating hospital in the United States, call the National Cancer Institute's (NCI) Cancer Information Service at (800) 422-6237 or visit the NCI's clinical trials Web site at http://cancertrials.nci.nih.gov. Information also is available on the NSABP Web site at www.nsabp.pitt.edu. ▼

## Kit helps partners cope with cancer

Two communications giants have joined forces to develop a kit to help couples deal with the challenges of facing breast cancer together.

Samsung Telecommunications in Dallas and Sprint PCS in Kansas City, MO, with the help of the Johns Hopkins Breast Center in Baltimore, have developed a free, limited-edition support kit, "Journey of Hope: Couples Speak Out About Breast Cancer." The kit includes a workbook and video that emphasize the need for communication between partners and help couples discuss such sensitive issues as intimacy, spirituality, finances, and long-term survivorship.

In "Journey of Hope," breast cancer survivors and their partners share their personal experience about how they supported each other and dealt with a variety of difficult issues during their battles with breast cancer.

To receive the kit, call (877) 718-4673. More information is available on the Web at www.breastcancerinfo.com. ▼

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