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Covering Case Management Across The Entire Care Continuum

INSIDE

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Resource Bank

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Professional Development

Case managers must be the source for solution in conflict control

Here's how you can learn to defuse emotional patients

Conflict thrives in competitive and uncertain environments, and no industry in the United States today is more competitive or rife with uncertainty than health care.

The new millennium brings with it a change in the way businesses view conflict resolution, and in the case of the health care industry, case managers are often an organization's first line of defense. Make no

CM caseload survey results are in!

More than 520 case managers representing 10 practice settings responded to the first case management caseload survey conducted by American Health Consultants in Atlanta, publisher of *Case Management Advisor*, and the Case Management Society of America in Little Rock, AR.

We now know that roughly 53% of respondents spend 26% or more of their time working with clients telephonically. We also found that nearly 30% of respondents report their organizations assign cases based on geographic location.

Look for more results of this exclusive national case management caseload survey in the April issue of the newsletter. The executive summary will be available soon on both the CMSA and American Health Consultants Web sites, so keep checking www.ahcpub.com and www.cmsa.org. In addition, look for in-depth articles about the increasing significance of managing caseloads in upcoming issues throughout 2001. ■

mistake — how you handle frustrated patients and overburdened providers directly affects your organization's bottom line. Learning to keep your cool when those angry calls come in is a skill that will make you even more valuable to your organization than you are right now and, more importantly, just may prevent minor disputes from becoming major lawsuits.

"Case managers must view themselves as diplomats and problem solvers," says **John P. Biancardi**, MA, chief training officer for Conflict Solvers, a health care training firm in Laguna Niguel, CA, which specializes in conflict resolution and mediation. "If I'm in the middle of a battle and the bullets are flying, I want General George Patton by my side. However, if I'm trying to bring an end to the war, or keep the war from escalating for that matter, I want former Secretary of State Henry Kissinger. It's time for case managers to develop a new mindset. Don't be task-oriented," he urges. "Tell yourself you are a problem solver, not an administrator."

Veteran case managers know that in many situations what a patient says he needs isn't the best, most appropriate, or most cost-beneficial option, adds **Marc Miller**, MD, president of Conflict Solvers, who formerly managed a case management department. "One of your jobs is to come up with options that address what the patient really needs."

"There is always a solution," adds Biancardi. "The case manager's job is to make the answer more palatable."

To put this in perspective: "Case managers, whether they work in a managed care organization or a hospital, often find themselves in positions of responsibility without the necessary authority they need to get things done," notes Miller. "I have seen case managers use mediation skills intuitively without a formal framework for what they are doing. If you, as a case manager, have mediation training, your effectiveness improves and you become an invaluable asset to your organization."

Dan E. Wax, Esq., general counsel for Conflict Solvers, agrees. "A single case manager trained in mediation methods can head off a future lawsuit," he notes.

Words to live by

So, how do you reinvent yourself as the Henry Kissinger of the health care industry? The key, says Biancardi, is to make the following three statements your work credo for 2001:

- I will exercise patience in the face of adversity.
- I will not take the anger of physicians, other providers, or my patients personally.
- I will be a problem solver.

The crux of problem solving is being able to defuse verbal attacks and prevent minor irritations from escalating into major headaches for your organization. The first step to solving a problem is to make sure you understand it. To do that, says Biancardi, you must become an "active listener."

Active listening is an excellent method for defusing and disarming verbal attacks, says Biancardi. "Active listening is the primary skill for managing conflict during emotional and value-laden discussions. It's a communication skill in which the listener hears and feeds back accurately the emotional content of a speaker's message," he says.

This feedback, explains Biancardi, serves these four main purposes:

- to demonstrate to a speaker that the message has been heard;
- to let the speaker know that the emotional intensity of the message has been heard;
- to legitimize the fact that having and expressing these emotions is acceptable;
- to build feelings of empathy between the listener and speaker.

Simple as 1-2-3

"Most of the time an angry caller is just looking for someone to unload on," says Biancardi. "Active listening is a skill that goes way beyond just saying 'uh-huh' or 'OK' occasionally just to let the caller know you're still there. Active

COMING IN FUTURE MONTHS

- Will offering injury protection programs save workers' comp costs?
- Numbers are in! Results of exclusive national caseload survey
- Can CMs help belligerent workers and management avoid litigation under ADA?
- Mainstreaming spiritual care into treatment plans
- How is the graying of America affecting workers' comp?

How to build a better 'feelings' vocabulary

Is the caller 'miffed' or 'furious'?

Not all words carry the same weight, even when they have very similar meanings. To be successful in validating the feelings of your next angry caller, make sure you have an arsenal of words ready to capture the correct degree or level of the caller's emotion, suggests **John P. Biancardi**, MA, chief training officer for Conflict Solvers, a health care training firm in Laguna Niguel, CA, which specializes in conflict resolution and mediation.

"The two primary feelings case managers must deal with are anger and frustration," he notes. "Telling an angry caller they sound 'upset' or 'miffed' simply doesn't cut it, if your caller is truly angry. If I use either of those words, I've missed the level of the caller's anger and lost any hope of gaining the caller's cooperation and possibly resolving this conflict at the same time."

Case managers don't have to be mind readers to gauge the level of a caller's emotion, but with a little practice and an adequate "feelings" vocabulary, case managers can develop a more sensitive emotion barometer, Biancardi says. He adds that case managers should not underestimate the value of finding the appropriate word to match their caller's emotional state.

Biancardi compiled the following list of words to help describe emotions case managers must deal with regularly. The words are listed from "mild" to "moderate" to "high" levels of emotion.

Anger: annoyed, discontented, miffed, perturbed, irritated, agitated, aggravated, furious, livid, outraged.

Distress: confused, puzzled, baffled, hindered, dissatisfied, offended, disgusted, sickened, anguished.

Fear: uncomfortable, tense, anxious, concerned, apprehensive, agitated, panicky, frantic, desperate.

Belittlement: neglected, ignored, ridiculed, discredited, maligned, abused.

Depression: unhappy, discouraged, lonely, blue, downcast, excluded, left out, abandoned, mistreated, crushed, despondent.

Inadequacy: helpless, powerless, unimportant, exhausted, useless, inferior, demoralized, broken.

Elation: at ease, calm, glad, cheerful, good, happy, excited, content, enthusiastic, ecstatic.

"Case managers must never forget that there are several degrees of emotion between 'miffed' and 'enraged.' If you make the mistake of downplaying the degree of someone's emotion, you won't be a successful conflict solver," warns Biancardi. **(See stories on the cover and p. 44 for more tips on how to become a skilled conflict solver.)**

However, he cautions, it's not enough to accurately gauge your caller's emotional state. You also must be as concrete as possible when you validate the caller's feelings. For example, Biancardi explains that saying, "You seem to be angry," is not as effective as saying, "You seem to be angry that Dr. Jones is no longer a preferred provider under your health plan." ■

listening goes straight to the heart and lets the caller know you really understand where they're coming from."

There are three important techniques for active listening, he notes. Those are:

1. Reframing. Reframing is your attempt to paraphrase the speaker's statement while conceptualizing it in a different context, says Biancardi. This can be done, he says, by changing the wording of the speaker's message so that the speaker will listen and hear the "real message."

It also helps, Biancardi notes, to begin "turning the focus away from the speaker's position and defining the problem in terms of mutual interests. You have to learn to turn negative statements into positive statements. When the caller expresses a negative attitude, express the positive value. People may be 180 degrees apart and still have mutual interests."

• **Example A:** The caller says, "I've been paying you people premiums for a long time now, and the first time I really need you, you tell me 'no.' What does HMO stand for anyway, Hand Money Over?!"

— Reframing possibility: "What I think I hear you saying is, from your perspective, you've kept your part of the bargain by paying your premiums faithfully, but it seems to you that we haven't kept ours."

— Or: "Just so I understand, although you've

Resolving conflict on-line requires a careful touch

Always pause before pressing 'send'

E-mail offers case managers a quick and easy way to reach busy doctors or respond to a question from a patient in the middle of a busy day. However, it also creates a written document, and that means case managers must take the time to read back their e-mail responses before pressing "send," say health care mediation experts.

"Case management is a critical function within health care organizations," says **John Biancardi**, MA, chief training officer for Conflict Solvers, a health care training firm in Laguna Niguel, CA. "You must be hyper-vigilant when you communicate by e-mail. Always give yourself time to pause, read back what you've written, check your grammar and your word choice. Ask yourself, how is this going to be received? Remember, once you press 'send,' it's too late to go back and make changes."

Marc Miller, MD, MBA, president of Conflict Solvers and a former supervisor of case managers, adds that any e-mail a case manager sends must also be HIPAA (Health Insurance Portability and Accountability Act) compliant in terms of protecting patient confidentiality. "The last thing you want is for a quick e-mail to come back and haunt you," he stresses.

In addition, Miller urges case managers to avoid ambiguity in their e-mail correspondence. "When you communicate with someone in person or by phone, if they don't understand you, they can ask you for clarification. When you e-mail, if your message is unclear, you run the risk of creating a misunderstanding or appearing to agree to an [unintended] course of action."

Case managers should also avoid the use of "jargon" in their e-mail correspondence, notes **Dan E. Wax**, Esq., general counsel for Conflict Solvers. "This is particularly important to avoid if you are communicating with a patient. Remember, you must always give more explanatory information in a written communication than in a verbal communication."

Verbal communication gives case managers more tools to use when the purpose of communication is to defuse conflict, but e-mail also has distinct advantages, notes Miller. "Verbal communication gives you a personal touch. You can use your tone of voice as an additional tool. However, e-mail has the advantage of being one-directional. It gives you time to compose a thoughtful response and weigh it carefully before sending it." **(For tips on more effective verbal communication, see the cover story.)** ■

paid your premium faithfully, you feel you have not received the services which we have agreed to provide."

• **Example B:** The caller says, "Look, whoever you are, I am sick and tired of being put on hold, or into someone's voice mail who never gets back to me. I want answers, not the runaround."

— Reframing possibility: "If I hear you correctly, it sounds as if you've made several attempts at getting answers, but either we didn't respond, or our answers were unsatisfactory."

— Or: "If I've heard you correctly, it sounds as if you feel we've dropped the ball, or haven't given adequate explanations when you have called us."

Biancardi stresses that it doesn't matter if you've measured the caller's situation accurately as long as you make an honest attempt. "It's your attempt to get to the real message that counts, not your accuracy in interpreting it," he says. "Eventually, reframing will get you to the real message behind what was said."

2. Asking questions. In this case, cautions Biancardi, it's not enough to simply ask questions. The key is to ask questions that invite responses.

Often the first word of a question leads to a variety of responses and results, he explains. For example, "what" questions lead to facts; "how" questions lead to feelings; "why" questions lead to reasons. "Questions help you defuse an angry caller in several ways," he adds. "They help begin the communication. They also open new areas of discussion and clarify issues."

Biancardi likes to open with "could" questions. "'Could' questions invite a response. A 'could' question says, without actually putting the thought into words, help me to help you."

Good opening questions include:

• Could you tell me more about your situation?

• Could you give me an example of what you're telling me?

He cautions that the way questions are framed can either "open" or "close" a dialogue. Open questions are those that require more than a few words to answer and encourage people to provide maximum information, while closed questions can easily be answered in very few words.

In addition, he suggests case managers practice reframing statements as questions. "This is an active listening technique which lets your caller know that you've been listening closely to him," says Biancardi. "But don't overdo it. If you overuse this technique, it becomes annoying to the listener rather quickly."

3. Validating the speaker's feelings. "There's an accepted stereotype that women are taught to express feelings more than men and that . . . women have a better 'feelings vocabulary' to refer to when they need it," says Biancardi.

If you downplay the level or degree of emotion your caller is feeling, you risk escalating the caller's anger and missing an opportunity to resolve the caller's conflict, he notes. "I don't expect case mangers to be mind readers. But I do think with practice a case manager can honestly and genuinely assess the level of someone's emotion in the course of a three- to 30-minute phone call." **(For a list of "feelings" words to add to your mental toolbox, see p. 43.)**

"Remember, part of your job is customer relations and learning skills such as active listening can take you a long way," says Biancardi. "Case managers are on the front line and learning to defuse hostility, whether in providers [or] patients, prevents a variety of problems from plan abandonment to future lawsuits."

The simple art of active listening may be all that's required to defuse a potentially volatile situation, he adds. "The simple fact that I called and you allowed me to vent is sometimes enough. Sometimes, patients make outrageous requests. They want to go to a heart specialist in Switzerland and expect the health plan to pay for it. If you can listen actively and patiently, you can often start moving the patient through a menu of more reasonable options — like maybe a heart specialist locally who has a national reputation and also is part of your network."

"If you've done a good job listening and reframing the caller's message, the caller will be more willing to listen to your explanation for why [his request] isn't possible," stresses Wax. ■

Urge patients to report drug use accurately

Many Americans run risk of drug interactions

More than 50% of American adults take two or more medications daily. Yet, nearly 10% don't inform their physician, case manager, or hospital personnel about medications they are taking. Still more alarming, only 3% of Americans report bringing their prescriptions with them when they are admitted to the hospital, according to a survey of 1,000 Americans commissioned by the American Society of Health-System Pharmacists (ASHP) in Bethesda, MD.

Not surprisingly, rates of prescription drug use were highest among older Americans. Nearly 80% of respondents age 65 and older reported taking one prescription medication each day compared with 63% for Americans age 55 to 64 and 52% for Americans age 45 to 54. In fact, Americans over age 65 who take prescription medications take an average of four each day.

Other findings include:

• Of respondents who did report their medication use, 39% told a physician or a nurse.

• Sixty-one percent of respondents reported their prescription drug was for a long-term health condition.

• Twenty-four percent of respondents reported their prescription drug was for a short-term condition.

• Fifty-eight percent of respondents reported taking an average of two non-prescription drugs in the previous week.

• Roughly 33% of respondents said they take an average of two non-prescription drugs daily.

• Thirty-nine percent of respondents reported taking an average of four vitamins or herbal supplements in the previous week.

• Forty percent of respondents reported taking an average of two herbal supplements or vitamins daily.

8 steps to safer drug use

"Our survey shows that consumers are simultaneously using a variety of prescription and non-prescription medications, as well as herbal supplements and vitamins," says ASHP President **Mick L. Hunt**, MS. "We want consumers to be aware of the danger for potential drug interactions

that can occur when mixing all of these remedies, especially when taking multiple medications each day."

To ensure that medications are used safely and effectively, the ASHP recommends that case managers advise patients to take the following steps:

1. Keep a list of all drug therapies, including prescription and non-prescription drugs, home remedies, and medical foods, and bring that list to their health care provider.
2. Communicate actual self-medication practices to health care providers, especially if the way the medication is taken varies from the originally prescribed directions.
3. Contact their health-system pharmacist with any questions regarding treatments or drugs.
4. Learn the names of prescribed drug products as well as their dosage strengths and schedules.
5. Ask their health care provider or pharmacist whether there are certain foods, beverages, other medicines, or activities that should be avoided while taking a prescribed medication.
6. Request available written information on the drug.
7. Question their pharmacist or health care provider about anything they don't understand or that doesn't seem right.
8. Be alert to unexpected changes, such as receiving a prescription refill that seems to have a different strength or appearance from the original prescription. ■

Long-term Care/Geriatrics

Device heals chronic wounds quickly

Necrotic tissue appears to regenerate

A new electronic device successfully healed the most stubborn chronic wounds in six weeks or less. It also regenerated necrotic tissue, making surgical intervention unnecessary, according to the results of a study presented at The American Academy of Anti-Aging Medicine's 8th International Congress in Las Vegas. With an aging population increasingly at risk for chronic wounds and the cost of chronic wound care expected to exceed $2.4 billion by 2006, according to industry reports, the ElectroRegenesis Therapy Device (ERTD) manufactured by ElectroRegenesis in Pacific Palisades, CA, holds great promise to heal wounds more quickly and thoroughly than currently available standard treatments.

The study, led by Bok Y. Lee, MD, professor of surgery at New York Medical College in Valhalla, included 25 chronic wounds with an average duration of three years not responding to standard conservative treatment. Wounds included long-term decubitus ulcers, amputations, diabetic lesions, and paraplegic and quadriplegic wounds.

All 25 patients in the study were hospital inpatients. The wounds were treated with a direct current of a maximum of 4 milli-amperes of one polarity for 11 minutes and then the current of the opposite polarity for another 11 minutes. A single treatment lasted 3 1/2 hours. Patients received five treatments per week until their wounds healed completely.

The average time to complete wound healing was 14 treatments, or about three weeks of treatment five times a week. "The longest time a patient took to heal was six weeks," notes **Alfred J. Koonin**, MD, director of medical research for ElectroRegenesis in Pacific Palisades.

"The ERTD represents a major advancement for treating the most chronic, treatment-resistant wounds," says Lee. "The device is a safe, non-invasive therapy for a range of serious, difficult-to-treat health problems."

ERTD eliminates surgery

Researchers also found ERTD eliminates the need for surgical debridement of necrotic tissue, says Koonin. "Many of the patients were very elderly and infirm, and would not have been candidates for surgery," he notes. "As the population ages, the need for less invasive treatment for chronic wounds becomes critical."

To qualify for the study, patients had to have had a chronic wound that failed to respond to standard treatment for at least three months. Patients continued their current wound management treatment while receiving ERTD stimulation.

The ERTD measures roughly 12 inches by 12 inches and stands about three or four inches high. ElectroRegenesis is also developing a smaller unit for home use. Neither unit has received approval from the Rockville, MD-based U.S. Food and Drug Administration.

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Reports From the Field™

Women's Health

Vertebral fractures signal trouble for older women

One in five women with postmenopausal osteoporosis who suffer a vertebral fracture, the most common type of fracture in people with osteoporosis, suffer a second vertebral fracture within a year, according to a recent article in the *Journal of the American Medical Association*.

The 2,725 postmenopausal women studied were enrolled in the control groups of four large clinical studies evaluating the therapeutic benefit of the osteoporosis medication risedronate. The women in the control groups received only supplemental calcium and, if needed, vitamin D.

Researchers analyzed data from all 2,725 women. Of the 381 women who fractured during the study, 19.2% fractured again within a year — even when taking 1,000 mg of calcium and supplemental vitamin D. The researchers further found that after some women suffer a vertebral fracture, there may be a fracture "cascade," or domino effect, says lead author **Robert Lindsay**, MD, PhD, chief of internal medicine at Helen Hayes Hospital in West Haverstraw, NY.

"These findings challenge the current tendency to diagnose and treat osteoporosis only after a fracture has occurred," Lindsay notes. "They demonstrate the need for osteoporosis treatments that work quickly to reduce fracture risk."

[See: Lindsay R, Silverman SL, Cooper C, et al. Risk of new vertebral fracture in the year following a fracture. *JAMA* 2001; 285(3):320-323. Additional reading: Harris ST, Watts NB, Genant HK, et al. Effects of risedronate treatment on vertebral and non vertebral fractures in women with postmenopausal osteoporosis: A randomized controlled trial. *JAMA* 1999; 282(14):1344-1352.] ■

Moms-to-be should kick caffeine, study confirms

A population-based study of early spontaneous abortion in Sweden found that the risk of miscarriage increases with increased caffeine intake, according to a recent *New England Journal of Medicine* article.

Researchers conducted a population-based, case-control study of early spontaneous abortions in 562 women who had spontaneous abortion at six to 12 weeks gestation and 953 women who did not have spontaneous abortions who were matched to the case patients according to the week of gestation. Researchers interviewed women about their caffeine intake. Plasma cotinine was measured as an indicator of cigarette smoking and fetal karyotypes were determined from tissue samples. Multivariate analysis was used to estimate the relative risks associated with caffeine ingestion after adjusting for cigarette smoking and symptoms of pregnancy such as nausea, vomiting, and fatigue. Results show that:

- Among nonsmokers, more spontaneous abortions occurred in women who ingested at least 100 mg of caffeine per day than in women who ingested less than 100 mg per day.
- Risk of spontaneous abortion increased with increased caffeine intakes with an odds ratio of 1.3 for women who ingested between 100 and 299 mg

of caffeine per day; an odds ratio of 1.4 for women who ingested between 300 and 499 mg of caffeine daily, and an odds ratio of 2.2 for women who ingested 500 mg of caffeine or more daily.

• Among smokers, caffeine ingestion was not associated with an excess risk of spontaneous abortion.

• When the analyses were stratified according to results of fetal karyotyping, ingestion of moderate to high levels of caffeine was associated with an excess risk of spontaneous abortion when the fetus had a normal or unknown karyotype, but not when the fetal karyotype was abnormal.

[See: Cnattingus S, Signorello LB, Anneran G, et al. Caffeine intake and the risk of first trimester spontaneous abortion. *New Engl J Med* 2000; 343(25):1839-1845.] ■

Drugs stop early labor, prolong pregnancy

A new evidence report from the Agency for Healthcare Research and Quality (AHRQ) in Rockville, MD, finds that certain drug therapies and diagnostic tools have a positive outcome on the treatment of preterm labor.

Researchers report that the use of tocolytics effectively stops uterine contractions during episodes of preterm labor and is an effective means of extending the length of the pregnancy. However, the research team also found that continued use of tocolytics after contractions subside offers no apparent further benefit.

The evidence report states that antibiotics also prolong the length of pregnancy and the infant's gestational age at birth, suggesting that there is validity to the theory that hidden infections of the upper genital tract do play a role in preterm labor but that their potentially harmful impact can be moderated.

In addition, the report found that two diagnostic tools, fetal fibronectin tests and endovaginal ultrasound, are effective in predicting which women with symptoms of preterm labor are at low risk of preterm birth. Researchers conclude that these two tests can usefully supplement clinical judgment, offering valuable information that helps avoid unnecessary treatments.

Further, after controlling for whether or not women received nursing support, the use of home uterine activity monitoring for women in preterm labor was not found to have an effect on the infant's gestational age at birth or birth weight.

The summary of the evidence report, *Management of Preterm Labor,* is available online at www.ahrq.gov/clinic/epcix.htm. Printed copies of the report are available from the AHRQ Publications Clearinghouse, P.O. Box 8547, Silver Spring, MD 20907. Telephone: (800) 358-9295. ■

Behavioral Health

Paxil packs on pounds, according to research

Clinically significant weight gain is five times more prevalent with Paxil (paroxetine HCl), than with Celexa (citalopram HBr), according to a study presented at the recent American College of Neuropsychopharmacology annual meeting in San Juan, Puerto Rico.

In the 28-week, randomized, double-blind, parallel group study, citalopram and paroxetine produced similar significant improvements on measures of anxiety and depression in 104 participants between the ages of 18 and 65. However, clinically significant weight gain occurred among 21.6% of paroxetine-treated patients compared to 3.9% of citalopram-treated patients. Researchers defined clinically significant weight gain as greater than or equal to a 7% increase in body weight.

"Weight gain is an extremely important factor in evaluating SSRIs (selective serotonin reuptake inhibitors)," says **James W. Jefferso**n, MD, clinical professor of psychiatry at the University of Wisconsin Medical School in Madison. "A weight gain of 7% or more is considerable for a patient who is suffering from depression and anxiety. This physical change may lead a patient to make a unilateral decision to end treatment." ■

Mood stabilizer costs less, causes fewer side effects

Results of a head-to-head study showed fewer patients reported side effects with the mood stabilizer Depakote (divalproex sodium delayed-release tablets) compared to patients taking the

antipsychotic olanzapine (Zyprexa), according to a study released at the annual meeting of the American College of Neuropsychopharmacology in San Juan, Puerto Rico.

In addition, for bipolar patients with acute mania, researchers found that there was no difference in the efficacy of the two drugs even though the cost of treating a patient with divalproex tablets is 50% lower than the cost of treating a patient with olanzapine.

The 12-week clinical trial included 120 patients randomized to receive either divalproex or olanzapine. During the trial, fewer divalproex patients experienced side effects than patients taking olanzapine.

Clinically significant findings include:

• The mean weight gain for patients on divalproex was 5.5 pounds compared to 8.8 pounds for olanzapine.

• 10% of divalproex patients experienced weight gain compared to 25% of olanzapine patients.

• None of the divalproex patients experienced edema compared to 14% of olanzapine patients.

• None of the divalproex patients experienced speech disorders compared to 7% of olanzapine patients.

• Three percent of divalproex patients experienced rhinitis compared to 14% of olanzapine patients.

The mean cost of 12 weeks of outpatient treatment was $550 for the divalproex group and $1,100 for the olanzapine group. Efficacy was similar in the two groups. ■

Heart Disease

Reduce salt to reduce risk of high blood pressure

Researchers recently confirmed that reducing salt intake is still good advice for patients with hypertension. In addition, the *New England Journal of Medicine* study found that reducing salt intake while following the DASH (Dietary Approaches to Stop Hypertension) diet lowers blood pressure even more effectively.

Researchers studied 412 participants, with and without hypertension, who were randomly assigned to eat a control diet typical of intake in the United States or the DASH diet, which is high in vegetables, fruits, and low-fat dairy products. Within the assigned diet, participants ate foods with high, intermediate, or low levels of sodium for 30 consecutive days each, in random order.

Findings include:

• Lowering the sodium intake from the high to the intermediate level reduced the systolic blood pressure by 2.1 mmHg on the control diet and by 1.3 mmHg on the DASH diet.

• Reducing the sodium intake from the intermediate to the low level caused additional reductions of 4.6 mmHg on the control diet and 1.7 mmHg on the DASH diet.

• The DASH diet was associated with a significantly lower systolic blood pressure at each sodium level, with the difference being greater with high sodium levels than with low sodium levels. For example, the DASH diet with a low sodium level led to a mean systolic blood pressure that was 7.1 mmHg lower in participants without hypertension and 11.5 mmHg lower in participants with hypertension.

[See: Sacks FM, Svetky LP, Vollmer WM, et al. Effects on blood pressure of reduced dietary sodium and the Dietary Approaches to Stop Hypertension (DASH) diet. *New Engl J Med* 2001; 344(1):3-10.] ■

Mild ischemia puts seniors at risk for cardiac death

A noninvasive heart scan may help identify which senior adults are at the greatest risk for cardiac death, according to a study presented at the recent 73rd Scientific Sessions of the American Heart Association in New Orleans. In addition, researchers say that their findings suggest that more aggressive treatment may be warranted in those elderly patients with only mild cardiac ischemia than is currently used in clinical practice.

Researchers evaluated the prognostic value of stress-induced ischemia in 15,081 patients referred for myocardial perfusion SPECT (single photon emission computed tomography) using Cardiolite (kit for the preparation of technetium Tc99m sestamibi for injection). Patients' risks were determined by the amount of ischemia evident on SPECT and adjusted by decade of life

from less than 60 years of age to 80 years of age and older.

The statistical threshold of increased cardiac death decreased with advancing age, researchers reported. Specifically, the 18-month survival rate was 99% for ≤ 70 years, 98% for 71 to 80 years and 94% for > 80 years.

The findings demonstrate, says lead researcher **Leslee J. Shaw**, PhD, associate professor of medicine at Emory University in Atlanta, that the ability of a noninvasive heart scan to accurately detect and assess the degree of cardiac ischemia is critical to early intervention and the long-term survival of patients. "With this new clinical evidence, we are another step closer to improving the management of this often under-treated patient population," he argues.

"While physicians already know the clinical value of Cardiolite in the general population, this study further points to its ability to accurately predict risk of cardiac death and guide clinical decisions in older patients," says **Daniel Berman**, MD, a study investigator and director of nuclear cardiology at Cedars-Sinai Medical Center in Los Angeles. "Furthermore, the findings of this study take on even greater significance when you consider that cardiac ischemia is the leading cause of death among elderly patients and that the elderly comprise an increasing percentage of the U.S. population." ■

FDA approves cervical dystonia treatment

Elan in Dublin, Ireland, received FDA approval for Myobloc (botulinum toxin type B) Injectable Solution for the symptomatic treatment of patients with cervical dystonia (CD) to reduce the severity of abnormal head position and neck pain associated with CD.

Myobloc works by interrupting the cholinergic transmission between the nerve and the affected muscle, causing the muscle to relax. As the first FDA-approved treatment for CD, Myobloc offers new hope for patients with this debilitating disease, says **Mark Lew**, MD, director of the division of movement disorders at the University of Southern California School of Medicine in Los Angeles and clinical trial investigator for Myobloc.

"Cervical dystonia can be a painful, disabling, and sometimes embarrassing disease," says Lew. "The FDA approval is very exciting, important news for patients."

Full prescribing information is available by calling (888) 461-2255. ▼

Drug melts blues away

Organon in West Orange, NJ, recently received FDA approval for REMERONSolTab, mirtazapine, orally disintegrating tablets, the first disintegrating antidepressant tablet.

The REMERONSolTab dissolves on the tongue in 30 seconds with or without water. The manufacturer suggests that the easy delivery method may improve patient compliance with antidepressant therapy; it is the only antidepressant tablet that does not have to be swallowed whole.

In addition to its delivery method, the drug has a unique pharmacological profile that increases levels of both norepinephrine and serotonin in the brain to fight depression. ▼

HCFA approves injectable iron treatment for anemia

Watson Pharmaceuticals in Corona, CA, recently announced two important decisions regarding Medicare reimbursement for its injectable iron product, Ferrlecit (sodium ferric gluconate complex in sucrose injection).

Medicare began reimbursing Ferrlecit as a first-line treatment of iron deficiency anemia in patients undergoing chronic hemodialysis who are receiving supplemental erythropoetin therapy as of Dec. 1, 2000. In addition, HCFA was assigned a Common Procedure Coding System code for Ferrlecit on Jan. 1. Ferrlecit has been assigned HPCS code J2915.

These two announcements give Ferrlecit a uniform coverage and billing procedure under Medicare. ■

(Continued from page 46)

"The unit is simple to use and our hope is that eventually patients will be able to begin initial treatment in an outpatient clinic and then use the take-home unit with the help of a family [member] or professional caregiver at home," says Koonin, adding that a much larger 10-center study of ERTD in 200 patients with chronic wounds is currently under way.

Before ERTD treatment, foam bandages soaked in ordinary tap water are wrapped above and below the wound. A black silicon bandage is wrapped over the foam bandage and wires leading from the ERTD are clipped to the silicon bandage.

None of the patients in the study experienced side effects from the treatment other than mild rashes from the wraps that resolved quickly once the wraps were removed. "Most patients don't feel anything except a mild tingling during treatment," says Koonin. "The current running on this machine is much lower than any other electric stimulation device in use medically for any condition."

Koonin notes that physicians who had been treating these patients "were more than surprised" at how quickly and completely the wounds healed. "Several patients had significant improvement in two treatments. None of the patients required surgery. Necrotic tissue appears to regenerate."

One unexpected side effect Koonin hopes will be better understood as results from the multicenter study are analyzed is the cognitive improvement seen in several patients with dementia included in the initial 25-patient study. "About half the patients in the study had some dementia. As a side effect of treatment, we noticed significant improvement in their cognitive behavior as treatment progressed."

[*Editor's note:* Further information on this study and the ERTD is available on the ElectroRegenesis Web site at www.electroregenesis.com. For further reading on the use of electrical stimulation for wound healing, see also: Sheffet A, Cytryn AS, Louria DB. Applying electric and electromagnetic energy as adjuvant treatment for pressure ulcers: A critical review. *Ostomy/Wound Management* 2000; 46(2):28-33, 36-40, 42-44. Gardner SE, Franz RA, Schmidt FL. Effects of electrical stimulation on chronic wound healing: A meta-analysis. *Wound Repair and Regeneration* 1999; 7(6):495-503. Kloth LC, McCulloch JM. Promotion of wound healing with electrical stimulation. *Advanced Wound Care* 1996; 9(5):42-45.] ■

Compression reduces post-surgical clotting

Obese patients run highest risk

Nearly 200,000 Americans undergo total hip replacement each year, according to the Health Care Financing Administration in Baltimore. Between 400 and 800 of those patients die in the first three months after surgery because a blood clot forms in a leg vein and later breaks off and lodges in the lungs. Still others develop a painful, swollen leg when a blood clot slows the flow of blood to the heart.

The problem is that both of these complications usually develop long after patients leave the hospital. Now, researchers from the University of California, Davis, report in a recent issue of the *New England Journal of Medicine* that pneumatic compression, using external devices that massage and compress the legs, dramatically lowers the risk of blood clot formation.

"This is also the first study to show that extended treatment with an anticoagulant drug lowers the risk of developing symptomatic blood clots," says lead author **Richard H. White**, MD, professor of clinical medicine at the University of California, Davis, School of Medicine and chief of the division of general medicine and director of anticoagulation services at the UC Davis Medical Center.

Yes, but does it hurt?

Past studies, notes White, have also looked at various clot-preventing therapies. These earlier efforts, however, used X-ray images of the veins rather than symptoms to determine the presence of blood clots, which develop in as many as 60% of hip-replacement patients. "Only a small proportion of clots cause symptoms — the rest disappear. So simply detecting clots does not determine which treatments, if any, truly prevent potentially serious symptoms."

Physicians are most concerned about the roughly 3% of hip replacement patients who develop symptomatic clots, he explains.

UC Davis researchers compared total hip replacement patients who actually developed symptoms of blood clots to patients who did not. They analyzed records of California Medicare patients who underwent hip replacement surgery

between 1993 and 1996. The medical records of 297 patients who were readmitted for a blood clot were compared to the records of 592 patients who were not readmitted and who presumably did not develop clotting symptoms.

Factors assessed include:

- pneumatic compression;
- anticoagulant therapy;
- body mass index (BMI).

"Our study showed that overweight and obese patients are most at risk for developing blood clots that require hospitalization," White says. Researchers found that overweight patients, or those patients with a BMI of 25 or greater, were 2 1/2 times as likely to have been hospitalized for clots as patients in the control group.

"We also found that specific groups of patients seem to benefit most from certain treatments." For example, White notes that pneumatic compression was most effective for patients of average weight, but did not reduce the risk of serious blood clots in overweight or obese patients. "Continuing anticoagulant drug therapy after discharge from the hospital was beneficial to all patients." Patients of all weights who continued therapy with the anticoagulant warfarin after they went home were only 60% as likely to have had symptoms as patients in the control group.

Further research may explain why obese patients develop more clots than patients of normal weight, White says. "But until we figure out what is going on, overweight patients appear to be the ones who need extended prophylaxis with warfarin or other anticoagulants."

[See: White RH, Gettner S, Newman JM, et al. Predictors of rehospitalization for symptomatic venous thromboembolism after total hip arthroplasty. *N Engl J Med*, 2000; 343(24):1758-1764.] ■

Disease Management

Nutrition plays key role in HIV/AIDS management

Experts suggest strategies to prevent weight loss

Clinical management of HIV / AIDS patients has never been more promising or more complex. New drug options not only greatly extend the life span of HIV patients but delay the onset of AIDS. However, they also cause a wide range of metabolic side effects that have raised new issues in the management of these patients.

"The highly effective treatment options now available to HIV patients have changed the nature of HIV," says **Vivian Sun**, RD, assistant director of nutrition services at Bellevue Hospital in New York City. "HIV is becoming a chronic disease and patients are developing diabetes and cardiovascular disease related both to lifestyles and as a side effect of drug therapy."

HIV patients today may well die of heart disease before they ever die of AIDS, adds **Ellyn C. Silverman**, RD, MPH, PA, president of ECS Nutrition Services in Long Beach, CA. "We are seeing a rise in chronic disease in HIV patients. We have cases of full diabetes hyperlipidemia. We have patients with fat redistribution from their bellies to the back of their necks which increases their risk of heart disease. And, on top of that, we still see cases of true AIDS wasting syndrome."

In a recent study of HIV patients taking highly active antiretroviral therapy, 42% had clinical wasting, notes **Alvan Fisher**, MD, medical director of the Coastal Medical / Reservoir in Providence, RI, and associate director of the Brown University AIDS Program. "With so many HIV / AIDS patients experiencing unintended weight loss," he stresses, "it is critical that case managers regularly monitor the nutritional status of their patients. Because weight loss can be a sign that a patient's overall condition is deteriorating, we need to identify early-on any appetite and weight loss before they become clinically significant — particularly in patients taking antiretroviral therapy."

Weighing in

Fisher, Silverman, and Sun agree that before beginning any nutritional intervention patients should receive a complete nutritional assessment and consultation. "In the Brown AIDS program, we evaluate and monitor nutritional status from the very beginning," notes Fisher.

The Brown AIDS program begins with baseline measurements of height and weight and an assessment of the patient's current diet. "From there, we move to monitoring lean body mass. At the earliest sign that weight is slipping, we step in with a range of interventions."

Sun and Silverman add that patients on

protease inhibitors should by monitored closely for lipodystrophy and diabetes. "The usual chemistries including cholesterol, triglycerides, albumin, glucose, and prealbumin should also be taken initially and then as needed," says Sun. "If the patient is HIV-positive, but asymptomatic and not taking protease inhibitors, these chemistries can be repeated every six months. If the patient is on medication, they should be monitored more closely."

Just looking at changes in body weight on the scale isn't enough to assess the cause of weight loss or the right option for correcting it, cautions Silverman. She also evaluates patients' energy levels and monitors thyroid function and testosterone levels.

"There are also socioeconomic issues which impact appetite and weight loss in HIV," Silverman notes. "Is the patient depressed? Does the patient have a past or current history of substance abuse? All of these things are relevant in assessing weight loss in HIV."

Anabolic agents and appetite stimulants are two common approaches to treat wasting and weight loss in people with HIV / AIDS, says Fisher. "However, the problem with many HIV patients is that if you put them on an appetite stimulant such as dronabinol [Marinol], they may gain weight but not lean body mass," he cautions. "Patients need an entire program of nutritional support, not just appetite stimulants. Anabolic agents are definitely indicated in men with low testosterone levels and low energy. If he's put on dronabinol, you had better make sure he's also given testosterone, too, and make sure he's not given megestrol acetate [Megace] which tends to make the testosterone issue worse."

Sun says an appetite stimulant should be considered for any HIV / AIDS patient when a nutritional assessment indicates the patient is losing weight and not eating enough. "Dronabinol is also effective if the patient is complaining of nausea caused by drug therapy."

She cautions that older patients may require lower doses of dronabinol. "If your patient is older make sure they are started on a lower dose and proceed with caution. Of course, if your patient has a history of substance abuse, he may need a much higher dose."

Other strategies Sun and Silverman suggest be considered either before or simultaneously with appetite suppressants to improve nutritional status of HIV / AIDS patients include:

- **Eating nutrient-dense foods.** Small, frequent, nutrient-dense meals are easier to tolerate than three large meals, agree Sun and Silverman.

"Nutritional supplements, such as Ensure or Sustacal, may be helpful for individual patients based on individual requirements," says Sun.

But Silverman discourages the use of nutritional supplements. "I'm not big on products like Ensure," she says. "They tend to be high in fat and sugar and not really that nutritious. In addition, they sometimes make patients nauseous."

Nuts, dried fruits, and granola bars make great snacks for patients to keep in their pockets or car, says Sun. "Apples and bananas also make great snacks for patients to keep in their car or office," she adds.

- **Drink before and after meals.** Silverman suggests patients drink water before and after meals, but not with their food. "Patients may fill up on fluids and not eat as much," she explains.
- **Eat with friends.** "You eat more when you don't eat alone," says Sun. "You sit longer and the food keeps coming."

Silverman agrees, adding, "Music is also a useful tool for stimulating appetites. I tell patients to invite a few friends over and have music playing in the background."

- **Exercise.** "Walking not only stimulates the appetite but it decreases depression. I recommend that patients walk daily," says Silverman.

In addition, she recommends weight resistance training for HIV / AIDS patients with muscle wasting.

- **Treat diarrhea.** "Many of the medications used to treat HIV cause diarrhea," notes Silverman. "Medical bulking agents like fiber and calcium carbonate can be helpful."

"What dieticians are very good at," says Silverman, "[is] identifying potentially high-cost complications and managing them early. We've proven that diet and exercise can effectively lower high cholesterol and high triglycerides and these issues are becoming more and more important in the management of HIV. If we can keep HIV patients off cholesterol-lowering drugs, we can not only keep their overall costs down, but we can also keep already complex drug regimens from becoming still more complicated."

(*Editor's note:* Marinol [dronabinol] is marketed by Roxanne Laboratories in Columbus, OH. For more information on Marinol, visit www.marinol.com. Megace [megestrol acetate] is marketed by Bristol-Myers Squibb in New York City. For more information on Megace, visit www.bms.com.) ■

Need to improve your HIV management skills?

Three-day course clarifies complex issues

New treatment options become available to HIV patients every few months. These options are increasing the life span of patients and delaying the time to the onset of AIDS. The new treatment regimens offer hope for patients, but the increasing complexity of such regimens as highly active antiretroviral therapy makes it difficult for case managers to keep abreast of clinical issues vital to maintaining the overall health of HIV patients.

Case managers in California no longer have to struggle alone to understand the complex clinical and social issues surrounding the management of HIV / AIDS patients. The San Francisco Department of Public Health offers a three-day certification course for nonclinical providers who work directly with HIV / AIDS patients. The course helps case managers identify inappropriate or conflicting drug therapies.

The goal of the Treatment Education Certification Program (TECP), says TECP trainer and coordinator **Claire Wingfield**, BA, is to offer comprehensive and fundamental information about HIV treatment so case managers can help clients make informed decisions about their health care. "HIV management means more than taking medication. It also includes information on eating better, getting more sleep, exercising. We want to help case managers empower people to manage their own health." **(For discussion on nutrition issues in HIV, see p. 52.)**

HIV 'experts' still have something to learn

The TECP helps case managers build an understanding of the nature of HIV. "Many case managers come to us thinking they don't need training," she notes. "But they leave thinking they've gained a new understanding. We take what can be stale scientific information and help case managers see how they can use information coming from ongoing HIV research to enhance their practice."

Topics covered in the three-day course include:

• **The immune system in the absence of HIV.** "We review the immune system and its normal function. We want to make sure that case managers understand how the immune system works before talking about how immunity is affected by HIV," says Wingfield.

• **The effect of HIV on the immune system.** "This material fascinates most participants," notes Wingfield. "We clarify how HIV turns the immune system and uses it against the patient. We go over how HIV turns the body's cells into factories and the importance of trying to reduce co-infections," she notes. "Case managers gain a new understanding of how, for example, contracting a sexually transmitted disease on top of HIV increases viral replication."

• **The life cycle of HIV.** "It's very difficult for case mangers to appreciate how the new treatment options work without understanding the life cycle of the virus," Wingfield says. "If you understand the life cycle, it's much easier to appreciate how the new medications work to disrupt that life cycle."

• **The consequences of immune suppression and opportunistic infection.** "We try to give case managers a language to use when working with patients and providers, and the red flags that signal there has been a change in the patient's immune system," Wingfield says.

"The case manager is not the clinical provider making the diagnosis and prescribing treatment," she notes, "but is the person monitoring the progress of the patient. The case manager is more likely than the physician to be the one first to learn that the patient has had diarrhea for three days straight."

Wingfield explains that the TECP trains the case manager how to direct the patient back to the primary care provider and enhance the provider / patient relationship.

• **The diagnostic tests.** The TECP also covers the diagnostic tests necessary to effectively monitor the health of HIV patients. "We cover how often they should be repeated as well as parameters that signal significant changes in health status," says Wingfield. "We also explain the need for specialized gynecologic care for women with HIV."

• **The new antiretroviral strategies.** Trainers cover not only available treatment options but also their side effects and how to enhance patient compliance, Wingfield notes. "We cover the latest research and clinical trials and how case mangers can find clinical trials their patients may want to participate in," she says.

• **The available resources.** The TECP also covers community resources and referral

information. "Case mangers new to the HIV community often aren't familiar with the food pantries and wide range of social services available to patients," says Wingfield, who once worked as an HIV / AIDS case manager in New York City. "These services are vital to maintaining the nutritional status and overall health of patients."

Participants take a pre-test on the first day of the three-day course. "We do this just to get a sense for what case managers already know about HIV," says Wingfield. "If anyone scores a 90% or higher, we give them the option to test out of the course and still become certified. So far, no one who has qualified has left."

Additional tests are given on days two and three. Participants must score an average of 90% or higher to become certified, says Wingfield, adding that 85% of participants pass at the end of the three-day course. "We offer one-on-one training for anyone who doesn't pass. We've never had anyone who couldn't pass the test after the one-on-one training."

The TECP is free to case managers living in the San Francisco Department of Public Health service area and costs $400 to case mangers outside the three-county area that includes San Francisco, San Jose, and Marin counties in northern California. In addition, the TECP provides course participants with a manual that includes materials and resources covered in the three-day course. The manual includes copies of slides used in training and fact sheets case mangers can copy and give to patients. The binders are available for $25.

In addition to the TECP, the San Francisco Department of Public Health sponsors three-hour monthly provider work groups, notes Wingfield. "We bring in experts to talk for several hours on new issues in HIV and hepatitis in an interactive group setting."

TECP trainers are also developing a one-day post-training course that covers new treatment options and issues such as the metabolic problems now cropping up in HIV patients such as diabetes, elevated lipids, and fat redistribution.

(*Editor's note:* The TECP was one of five programs recently recognized for exemplifying the principles of coordinated pharmaceutical care by the National Pharmaceutical Council in Reston, VA. Information on the other recognized programs is available at www.npcnow.org. Information on the TECP is available at www.dph.sf.ca.us.) ■

Michigan payers must cover diabetes supplies

CMs should brush up on diabetes education

Michigan recently joined California and Texas as one of 43 states that now mandate payers to cover necessary diabetes supplies and services. Gov. John Engler (R-MI) signed the law, which is the first health reform measure enacted in that state in more than a decade.

The Diabetes Cost Reduction Act requires Michigan-regulated health insurance and managed care policies to cover the following:

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Editorial Questions

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

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- insulin;
- oral diabetes medications;
- insulin pumps;
- blood glucose testing supplies;
- physician and diabetes education services;
- other supplies related to daily diabetes management.

Case managers working in Michigan should be aware that the new law also requires health plans to develop educational programs designed to prevent type 2 diabetes in at-risk Michigan residents. That's a tall order in view of a finding from the Centers for Disease Control and Prevention (CDC) in Atlanta that more than 2 million Michigan residents are at risk of developing diabetes. The CDC further reports that Michigan experienced a staggering 67% increase in the incidence of diabetes over the past decade. ■

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*

New videos help caregivers cope with dementia

Videos offer guidance for daily care

Fanlight Productions in Boston recently released two videos designed to help both family and professional caregivers understand and manage behavioral issues in Alzheimer's care.

In *He's Doing This to Spite Me: Emotional Conflicts in Dementia Care,* three caregivers share their experiences of conflict and frustration in interactions with their loved one who has dementia. These reflections are integrated with comments and guidance from professionals in dementia care. The program helps both family and professional caregivers reframe the patient-caregiver dynamic into one that is more comfortable and productive for both caregiver and patient.

The 22-minute video costs $179 to purchase or rents for $50 / day. Order #DD-311.

Dress Him While He Walks: Behavior Management in Caring for Residents with Alzheimer's Disease addresses several difficult behavior patterns common to Alzheimer's patients. It demonstrates practical ways of dealing with behaviors such as wandering, angry outbursts, and delusions.

The behavior of individuals with Alzheimer's rarely conforms to the usual social standards. This 20-minute video from the staff of the Alzheimer's Association of Miami, OH, helps caregivers adapt their expectations to each person's specific behavior patterns. In addition, because behavior change is no longer possible in individuals who can't understand or remember, caregivers learn to intervene only when truly necessary.

Topics covered include:

- behavior norms;
- behavior modification vs. behavior management;
- triggers to behavior challenges;
- behavior changes.

Although often difficult to watch, the video shows concerned caregivers dealing with difficult situations in a practical manner and with a sense of humor. It is suitable both as a training tool for nursing home staff and a discussion tool for family caregivers.

The video costs $139 or rents for $50 per day. Order #DD-310.

To request either of the videos described above, contact Fanlight Productions, 4196 Washington St., Suite 2, Boston, MA 02131. Telephone: (800) 937-4113. Web site: www.fanlight.com. ▼

CARF releases consumer guide and accreditation resources

Guide simplifies decision process for patients

Case managers often help clients make informed decisions about providers and treatment options. The Commission for Accreditation of Rehabilitation Facilities (CARF) in Tucson, AZ, recently released *How to Choose a Provider - a Guide From CARF* , a brochure that will simplify the task of helping clients and their families make decisions about selecting appropriate rehabilitation care or other services.

In a checklist format, the brochure suggests questions that patients and their families might ask to help make an informed and appropriate choice of providers. The questions help consumers determine if the provider's services match their needs, and analyze impressions when visiting a provider for the first time.

The brochure is available in both English and Spanish. Single copies of the brochure are sent at no charge to individuals who request a copy by calling the CARF office at (520) 325-1044, or writing to CARF, 4891 E. Grant Road, Tucson, AZ 85712. Requests should include a mailing address and whether an English or Spanish version is preferred.

If you wish to preview the brochure, the text is

also available online at www.carf.org/CARF/Consumer.htm in English or www.carf.org/CARF/ConsumerSpanish.htm for the Spanish version.

Bulk purchases of the brochure are also available to organizations to distribute. Ordering information for bulk orders can be found online at www.carf.org/Publications/Catalog.htm.

Accreditation help near you

Rehabilitation facilities preparing for CARF accreditation should check out these 2 1/2-day regional seminars coming to four cities in 2001. Called "CARF 101s," the seminars are designed to help organizations prepare their medical rehabilitation services for CARF accreditation, including help meeting CARF's new case management standards, and to provide guidance for improving the quality and value of their services.

The $425 seminars provide an overview of the CARF accreditation process and a comprehensive review of each section of the newly published *2001 Medical Rehabilitation Standards Manual*, including specific program standards. Dates and sites for regional seminars in 2001 are:

- April 2-4 at the Doubletree Colonnade in Baltimore;
- June 13-15 at the Le Meridien in Dallas;
- Sept. 10-12 at the Embassy Suites Hotel at the Orlando Airport in Orlando;
- Oct. 15-17 at the Sheraton Arlington Park in Chicago.

The cost of the seminar includes a copy of the 2001 standards manual. Space is limited and early registration is recommended.

Next best thing

If you can't attend one of CARF's regional seminars, you can take the self-study approach and request the newly released *2001 Medical Rehabilitation Survey Preparation Guide*. The guide accompanies the 2001 standards manual and contains all the standards that will be applied on surveys beginning July 1, 2001.

The new format for the survey guide is available in both print and CD-ROM versions, and provides a survey toolbox for understanding the intent of the CARF standards. The guide includes grids and checklists not available in previous versions.

The *2001 Medical Rehabilitation Survey Preparation Guide* (item #5125.40) costs $80 plus shipping and handling for the print version, and $150 plus shipping and handling for the CD-ROM version (item #5125.19). A set of both print and CD-ROM versions (item #5125.20) costs $220 plus shipping and handling.

The *2001 Medical Rehabilitation Standards Manual* (item #5110.40) costs $160 plus shipping and handling. The compact *Medical Rehabilitation Standards Manual - Standards Only Edition* , which does not contain the intent statements found in the full-size manual, makes a convenient referencing resource and is sold only in combination with the full-size manual for a cost of $280 plus shipping and handling for the set (item #5110.73).

Other companion publications available for 2001 include:

- *Medical Rehabilitation Standards Conformance Checklist* (item #5115.40), $40 plus shipping and handling. This was originally designed as a surveyor's tool and provides a method for tracking conformance to each standard.
- *Medical Rehabilitation Standards Audiotape* (item #5170.14), $25 plus shipping and handling. This audio tape is designed as a staff education tool to update key personnel on changes made to the standards in the past two years.
- *2001 Accreditation Sourcebook* (item #5105.70), $65 plus shipping and handling. This resource is designed for organizations new to accreditation. It includes survey preparation timetables.

A downloadable publications catalog is available at www.carf.org/Publication/Catalog.htm. A printed catalog and order form can be requested by calling (520) 325-1044, and then pressing "3" on the main menu. ■

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. ■