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Professional Development: Results of a National Survey

National health care faces major nursing crisis: 'It's time for action'

CMs must be ambassadors for the profession

This is not the nation's first nursing shortage, but the current nursing deficit threatens to be very different. What's new this time? American nurses are aging at a time when nursing school admissions have hit an all-time low and the nation's patients are getting sicker. It's time, say case management industry leaders, for case managers to start some serious crisis management.

"There isn't a case manager today who does not see the erosion of quality health care in terms of safety, outcomes, and patient satisfaction," argues **Catherine Mullahy**, RN, CRRN, CCM, president of Options Unlimited, a case management company based in Huntington, NY, and president-elect of the Case Management Society of America (CMSA) in Little Rock, AR. "As professionals," she explains, "we have a strong responsibility to advocate for those individuals who are now or in the future will be recipients of that health care delivery system."

Without an adequate pool of RNs, notes Mullahy, "our very case management plans are in jeopardy — to say nothing of our patients themselves. There will be a trickle-down-and-out effect as we look to others who are less qualified to put our plans in motion."

Sandra L. Lowery, RN, BSN, CRRN, CCM, president of CCMI Associates, an independent case management company in Francestown, NH, and national president of the CMSA, adds, "Case managers of all disciplines should support any and all efforts to increase the capacity for health care services that are needed or we will not be able to achieve our goals."

Health care professionals have a responsibility, agrees **Jacqueline J. Birmingham**, BSN, MS, RN, CMAC, executive director of Continuum

Care Services in Suffield, CT, to "safeguard patients, and the nursing shortage must be addressed. Unfortunately, nursing has done little until now to upgrade its image and functions, to align itself with the available changes in technology. We've groaned and moaned enough — it's time for action."

Barbara A. Kuritz, RN, CCM, clinical manager for national accounts with Aetna in Philadelphia, encourages case managers to actively take steps "to counteract the nursing shortage. We must be ambassadors for our profession in all of our social interactions. This is essential to recruiting qualified people into nursing and case management."

How real is this nursing shortage? Birmingham's alma mater just closed its doors after 60 years of nursing education due to diminished enrollment. And that's just one disturbing sign of the rocky days ahead.

Consider these facts pulled from the current literature:

- The number of nursing graduates taking the nursing exam in the state of Georgia dropped from 2,062 in 1997 to 1,130 in 2000.
- There was an overall 13.6% decline in the total number of nursing school graduates between 1995 and 1999.
- The Division of Nursing of the Bureau of Health Professions in Rockville, MD, predicts demand for full-time equivalent RNs will begin to exceed supply by 2010.
- The present average age of employed RNs is 43.3 years, with RNs who are less than 30 years old representing only 10% of the total nurse workforce.
- The majority of nursing school associate and assistant professors are between 49 and 52 years old. **(Selected references appear at the end of this article.)**

Who will do CM?

Not only does the impending nursing shortage have grave implications for the quality of direct patient care, it also directly affects who will provide case management services. Case management has always been a multidisciplinary health care profession. However, more than 60% of the respondents to the American Health Consultants / CMSA *2000 Case Management Caseload Survey* were RNs. Another 32.6% reported having a bachelor's or master's level preparation in a health care profession, and the vast majority of those respondents held degrees in nursing. **(See box on p. 91 for more on the caseload survey.)** If nursing school enrollments continue to decline, where will tomorrow's case managers come from?

"Anticipating a shortage of qualified individuals in nursing and in case management, I think there will be those who feel they may have to accept less and lower the bar on requirements and expectations for health care staffing," notes Mullahy. "I believe the CMSA needs to maintain its standards and to publicly, through position statements and press releases, underscore how important we believe it is to have qualified individuals providing services in these advanced practice settings."

The CMSA clearly does not advocate that case managers must have a nursing background, but rather advocates that case managers must have a background in a health care profession. "CMSA does not limit the qualification to practice case management only to RNs," notes **Peter Moran**, BSN, MS, RN, Cm, CCM, nurse case manager with Harvard Pilgrim Health Care in Wellesley, MA, and chapter president's representative for the CMSA. "I support having case managers trained in a health care profession — not necessarily nursing." **(See articles on pp. 81, 83, and 84 for further discussion of qualifications for case managers.)**

The nursing shortage may not only change who does case management, but also what case managers do, suggests **Linda DeBold**, RN, MSN, ARNP, ABQAURP, regional manager of case management for Broward General Medical Center in Fort Lauderdale. "I see the role of the case manager becoming more clinical and less social work related — especially in the acute care setting — in order to accomplish the necessary

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components of safe discharge. The very fact that we are faced with nursing units staffed with fewer RNs means the responsibility must shift to the case manager to be the strong link in the discharge and in efficient treatment plans being carried out."

No matter what their personal views on which health care professionals make the best qualified case managers, most case management industry leaders support efforts to actively recruit new nurses. The first step to reversing this disturbing trend may be understanding the factors leading to the current decline in nursing school enrollment and nursing staff recruitment and retention.

Moran and Mullahy cite the following factors as contributing to the current nursing crunch:

- lack of prestige associated with the nursing profession;
- more diverse opportunities with better working conditions available to qualified applicants;
- sense of powerlessness to change a failing health care delivery system;
- practicing RNs discouraging young people from entering the profession.

Several national nursing associations, including the American Nurses Association (ANA) and the American Organization of Nurse Executives, both based in Washington, DC, formed a coalition called the Tri-Council and released "Strategies to Reverse the New Nursing Shortage," a white paper which defines and suggests countermeasures for the current nursing crisis. **(Information on the white paper, as well as several other useful resources addressing the nursing shortage and the future of health care, appears on p. 90.)**

Recommendations advanced in the Tri-Council white paper include:

- developing career progression initiatives for nurses that move nursing graduates to graduate studies more rapidly;
- identifying the range of options available to nurses beyond entry-level roles;
- instituting an education and practice system which promotes more equitable compensation for nurses;
- reaching out to youth through counselors, youth organizations, schools, and community groups to promote nursing students;
- rewarding experienced nurses for serving as mentors and preceptors;
- establishing appropriate management structures within the health care system to ensure adequate staffing and providing nurses with autonomy over their practices;
- advocating for better identification of registered nursing services within Medicare, Medicaid, and other reimbursement systems;
- investigating the possibility of using technological advances to enhance the capacity of a reduced nursing workforce.

CMs respond to national survey

The first annual American Health Consultants / Case Management Society of America (CMSA) *2000 Case Management Caseload Survey* was distributed in the December 2000 issues of seven American Health Consultants newsletters, including *Case Management Advisor*. In addition, the survey tool was available on-line at www.ahcpub.com and www.cmsa.org through mid-January 2001.

A total of 522 case managers representing a wide range of practice settings responded either on-line or by fax. The largest response rate came from acute care case managers who composed 36.5% of the total respondents.

Other case managers represented in the data set include:

- Nearly 13% were employed by independent case management companies.
- Roughly 22% were health plan or health insurance case managers.
- Roughly 13% were workers' compensation case managers.

Next month, we will complete our analysis of the survey results. Our focus will turn to the case management process as we ask industry leaders to examine how much time case managers reported spending on each of the six core components of the process, and to explore the issue of whether the process identified by CMSA in its 1995 "Standards of Practice for Case Management" still applies to case management today.

An executive summary of the entire data set is now available on-line. Visit www.ahcpub.com and click on "Hot Topics in Healthcare." In addition, a white paper analyzing the data set by practice setting will be released in June 2001 at CMSA's "11th Annual Conference & Expo: Creating the Connection" in Nashville, TN. ■

Local solutions to national crisis

Anne Llewellyn, RN-C, BPSHA, CCM, CRRN, CEAC, owner and independent case manager with Professional Resources in Management Education in Miramar, FL, urges case managers to go out into their communities and local schools. "Case managers who are nurses can partner with efforts launched by groups such as the ANA, large hospital systems, and regional organizations to improve the image of nursing among young people."

Moran adds that case managers should take an active role in local, state, regional, and national efforts to address the nursing shortage and other problems within the health care delivery system. "Attend town meetings and national policy meetings," he urges case managers. "In two states in which I am licensed, Massachusetts and Maine, RNs have been asked to decide whether to remain part of the ANA or consider splintering off from the ANA and focusing their resources at a state and local level. In both votes, RNs chose to stay affiliated with the ANA, but the debate continues.

"Within case management we have the recent formation of the ACCM [Academy of Certified Case Managers], an organization set up for 'certified case managers' only. I feel these movements to splinter national professional associations are a mistake," argues Moran. "I believe to be truly able to impact decisions on health care we need to be invited to sit at the table and be part of the discussions. If we are not represented at all levels, our interests and concerns will not be heard."

Mullahy also encourages case managers to add their voices to the national debate on health care quality. "We need to be much more active than we have been willing to become. For example, we now have Health Insurance Portability and Accountability (HIPAA) and Prospective Payment Systems (PPS) legislation, major rulings that will affect how case managers will work within the delivery system and how individuals will get services," she notes. "Most of us heard rumblings about these legislative issues and adopted a wait-and-see stance, choosing to respond retroactively once we knew how these rulings might affect us.

"Instead," Mullahy urges, "we should assume that virtually every piece of health care legislation is going to impact our patients and the way we provide services. We had opportunities to be involved in the HIPAA and PPS legislation before they were finalized, and we did not step up. I'm not certain that these legislative initiatives will improve things for our patients; in fact, it appears to make our already convoluted system even more complicated. Now, we are faced with the nursing shortage — we must be included as solutions to the crisis are proposed."

Moran also advocates for active recruitment of new case managers. "I believe we have a good story to tell and must be more proactive about telling others who we are and how we can positively impact outcomes for clients," he stresses. "We must welcome new members and not eat them up and spit them out. We must get out into the community and let people know what we do. And, we need case managers to volunteer to mentor peers and new case managers as they enter the field."

Case managers also can help their friends, family members, and clients take a more active role in safeguarding the health care services they receive, notes Llewellyn. "I assist friends and family members in finding resources in the community with good providers who have proven their reliability," she says. "Also, I educate people about their need to be alert while navigating the health care system. I urge them to ask questions, read information, and take part in the process. Now is not the time to be passive!"

Patient support crucial

Families and other social support systems will be increasingly important as we begin to feel the impact of the nursing shortage, agrees **Jeanne Boling**, MSN, CRRN, CDMS, CCM, executive director of CMSA. "Currently, it is not advisable for a person to enter an acute care setting without someone to advocate for them while they are compromised. As a practical matter, she adds, "patients can no longer depend on their health care institutions to provide that advocate. The worsening nursing shortage will only emphasize that fact. Families and extended community lay support will become increasingly vital to good outcomes in the near future."

Mullahy agrees, adding, "We're already seeing nonprofessional, more technical personnel, whether personal care assistants, nursing technicians, or other paraprofessionals, at the bedside instead of nursing professionals. It has become accepted to have a non-nurse perform tasks that previously no one would think of having them perform. Nurses objected, but not strongly enough when these changes were instituted."

A local New York newspaper recently reported

that serious surgeries are being routinely rescheduled at local hospitals due to the nursing shortage, she relates. "The article cited problems at other regional hospitals, where, if nurses coming off eight-hour shifts balk at staying to work a second shift, supervisors may threaten them with patient abandonment charges."

Nurses, Mullahy explains, have not traditionally been outspoken self-advocates. "Nurses must educate consumers, physicians, and health care administrators, in terms they will understand, whether those terms relate to improved quality of care, dollars saved, or improved business operations, on the contributions of nurses and case managers. Until that happens, no one will really understand how serious this situation has become."

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Do case managers need clinical experience?

Industry leaders say it's nonnegotiable

Most organizations recognize the benefit of hiring case managers with a strong clinical background. Others not only recognize the value of clinical experience — they insist on it.

"The requirement for clinical experience is absolutely essential in a case manager who is managing cases involving catastrophically ill and/or injured individuals," stresses **Carrie Engen Marion**, RN, BSN, CCM, president of Advocare/Triage in Naperville, IL. "I have personally seen many examples of case managers who did not have the clinical experience they should have had to be managing the cases assigned to them. I have personally been called in to clean up situations where the case managers have clearly been outside the realm of their expertise which resulted in less than desirable outcomes, and, in some cases, unsafe situations."

It seems Marion is not alone in insisting that case managers have an adequate clinical background. More than 78% of respondents to the American Health Consultants/Case Management Society of America (CMSA) *2000 Case Management Caseload Survey* reported having more than 10 years of clinical experience compared to 0.6% who reported having less than one year of clinical experience.

Other findings included:

- Roughly 5% reported having one to two years experience.
- Roughly 5% reported having three to five years experience.
- Just more than 11% reported having six to 10 years experience.

"Case managers are called upon to take on many roles with each case," Marion says. "Many times the case manager has to be the coordinator of all services and health care professionals — the case manager acts as educator, negotiator, support system, and financial consultant."

Marion says the nursing shortage may make it more difficult for case management organizations to find professionals with extensive clinical experience. "The problem is that case management companies/departments may not be able to compete with the hospitals in the realm of salary and benefits, so may not be competitive in attracting professionals who are motivated by those factors," notes Marion. "There will always be companies in case management and managed care that think they can use non-health care professionals for these roles — it's happening today. It is not a way to do what I would call traditional and holistic case management."

It just takes time

"Clinical experience assures practical knowledge of real care implementation issues," stresses **Jeanne Boling**, MSN, CRRN, CDMS, CCM, executive director of CMSA. "Each case manager should practice within the scope of their expertise. A

healthy part of that expertise," she explains, "is a complete knowledge of the clinical and care implementation issues surrounding their clients. Although the knowledge base varies from practice setting to practice setting, the importance of clinical experience remains critical."

Linda DeBold, RN, MSN, ARNP, ABQAURP, regional manager of case management for Broward General Medical Center in Fort Lauderdale, says that in the acute care setting, clinical experience relates directly to "the success of accurate management of the case and the ability to follow a patient throughout the continuum.

"Without at least five years of experience," DeBold observes, "I have found that case managers lack the ability to gain the respect of the physicians and the nursing staff in the acute setting. Many times the case manager becomes the clinical resource nurse to the staff," she continues, adding that Broward General requires new case managers to have three to five years of clinical experience.

Of course, it's not easy to discuss the need for clinical experience without first agreeing on the meaning of that two-word phrase. "For nurses, clinical experience is best defined as full-time floor nursing in the acute care setting. I've observed excellent results when this full-time experience is in the critical care setting," notes DeBold. "Critical care nurses make excellent case managers because of their critical thinking skills and their ability to negotiate with physicians — two traits essential for good case management."

Basic training

For the owner of an independent case management company, the essential "experience" she seeks in new case managers includes basic training from an individual's health care discipline, actual clinical practice, life experiences, and willingness to listen to others with greater expertise. "Experience also comes from taking the time to talk and listen to patients," adds **Anne Llewellyn**, RN-C, BPSHA, CCM, CRRN, CEAC, owner and independent case manager with Professional Resources in Management Education in Miramar, FL.

As a manager hiring new case managers, DeBold says she looks for professionals with clinical experience which includes both critical care and telemetry. "Our hospital has only two units with no monitoring going on. I need case managers who understand the technology used."

Marion also requires a minimum of three to five years of clinical experience in new case managers, noting that this is a policy that is "fairly standard to most reputable companies. I know companies who hire new graduates to do case management. It's not in the interest of the catastrophic and very complex patients we serve to have someone with no clinical experience and/or judgment managing their cases," she says. "We also require [that] case managers have a level of critical thinking skills, including good written and verbal communication, decision making ability, and the ability to think outside the box — be creative."

But the bottom line is that without clinical experience, applicants need not apply, stresses Marion. "I can't give them that. Case managers have to know how to get the answers they are looking for and when to ask questions. Many new grads without that clinical experience don't know those things."

Case management in the gray zone

Peter Moran, RN, BSN, MS, Cm, CCM, nurse case manager for Harvard Pilgrim Health Care in Wellesley, MA, and chapter president's representative for the CMSA, says that inexperience may lead some new case managers looking for black and white answers in a sea of gray. "My concern about hiring inexperienced case managers," he explains, "is that many new professionals are looking for the right or wrong way to do things. Many will look at clinical guidelines and embrace them to the extent that suggested guidelines become their 'Bible' and enforced as if written in stone.

"Unfortunately," Moran continues, "much of what we do as case managers falls into what I call the gray zone, where there is no right or wrong answer and the guidelines don't make sense. Seasoned case managers are more apt to challenge the accepted guidelines and advocate for their clients. New case mangers are often fearful of rocking the status quo.

"I worry about organizations who may want to hire case managers who are green," he notes, "so they can train them the way they want to do case management. They may attract people who fear upsetting the system, and this isn't always in the best interest of our clients." ■

CCM certification ranks first on sheer volume

Nearly 70% of CMs earn CCMs

Many organizations encourage case managers to demonstrate their core competence by seeking a case management certification. A recent industry review by *Case Management Advisor* and its sister publication, *Hospital Case Management*, identified 12 certifications common to the case management industry.

However, the results of the American Health Consultants / Case Management Society of America (CMSA) *2000 Case Management Caseload Survey* indicate that the CCM (certified case manager) certification from the Commission for Case Management Certification (CMCC) in Rolling Meadows, IL, is by far the most commonly held certification with just less than 69% of case managers reporting having earned a CCM.

Other certifications held by respondents include:

- 2% reported earning a CMC (care manager certified);
- 3.7% reported earning a CRRN (certified rehabilitation registered nurse);
- 1.7% reported earning a COHN (certified occupational health nurse);
- 1.4% reported earning a CDMS (certified disability management specialist);
- 2% reported earning an A-CCC (continuity of care, advanced);
- 6.3% reported earning a RN-Cm (or RN-NCM, nurse case manager).

In addition, many case managers indicated by hand-written responses that they have earned multiple certifications.

"CCM was the first certification available to case managers," explains **Carrie Engen Marion,** RN, BSN, CCM, president of Advocare / Triage in Naperville, IL, who was the first chair of the CCMC and is currently serving again as CCMC chair until May 2001. "It is also the only certification that speaks to the needs of case managers regardless of practice setting and / or discipline. It transcends all lines whereas the other certifications depend on certain practice settings or disciplines and do not meet the needs of the entire industry."

Marion continues, "The CCM is also the only evidence-based credential which is based on available empirical research. The CCMC has the largest data bank of information about what case management is, the process of case management, and how it should be practiced based on information gathered from thousands of case managers, again, from all practice settings and health care disciplines."

Further, she notes, "CCM is accredited by a national accrediting agency that accredits certification bodies. That means CCMC has met some very rigorous standards in their role and function process, the exam process and the eligibility process which adds credibility and validity to the program."

The test of time

All of that aside, the CCM was quite simply the first on the scene and only time will tell, say others, whether it maintains its top-dog status. "Many CCMs were grandfathered in when the exam was first launched and are just recently renewing their certification," explains **Jacqueline J. Birmingham**, BSN, MS, RN, CMAC, executive director of Continuum Care Services in Suffield, CT. "When this grandfathered group leaves the profession, I fear the number of CCMs will drop dramatically. I predict this will happen in the next few years — it will be interesting to see what happens."

Birmingham argues that the CCM does not fit every case management practice and that case managers should search for other certification programs that better meet their own professional needs. "Case managers whose experience and current practice don't meet the CCM requirements should be directed to other accrediting bodies who certify the specialty in which the case manager practices. Certification is not one size fits all." **(Many case managers find their job descriptions do not meet the CCM eligibility requirements. See article on p. 84 for further discussion.)**

"When professionals are evaluating what certification they need," explains Marion, "they must do their homework and make sure they understand the basis of the certification, the eligibility process and the role and function or knowledge domains that the particular certification includes. Then, they must look at their own practices and decide which certification will benefit them most. Certification should not be simply a race to see who can get the most initials after their name."

Still, many employers advertise positions as "CCM-required" or "CCM-preferred," notes **Peter Moran**, RN, BSN, MS, Cm, CCM, nurse

case manager with Harvard Pilgrim Health Care in Wellesley, MA, and chapter president's representative for the CMSA. "I believe one reason for this trend is that accrediting bodies are asking health care organizations how they ensure their case managers have a basic understanding and the necessary skill sets to practice case management. By requiring case managers to have a nationally recognized certification, such as the CCM, health care organizations do not need to set up a rigid orientation and testing system for its case managers in-house."

Marion agrees, "CCM is recognized by buyers of case management services as well as the employers of case managers. This makes CCM very valuable to the industry as a whole."

Weighing the cost

Although it has become the "norm" to require certification to practice case management, some health care organizations resist requiring certification as a condition of employment, Moran says, to avoid "being asked to cover the cost of taking the exam, as well as the costs associated with continuing education units required to maintain certification."

Several states require certification in order for professionals to perform case management services in the workers' comp arena, notes Marion. "The CCM is one of the certifications mentioned in state legislation," she says, adding, "URAC" in Washington, DC, designed part of its Case Management Organization Accreditation program around the number of certified individuals in an organization, so it is becoming more important to have certified staff within a case management organization."

Yet, while health care organizations may not require their case managers to become certified, the profession does, argues **Jeanne Boling**, MSN, CRRN, CDMS, CCM, executive director of the CMSA. "Certification has not become a requirement for entry into the practice of case management," she says, "but a CCM, or like certification, is necessary for a case manager to continue seriously in a case management career path."

[Editor's note: See *Case Management Advisor,* November 2000, for further discussion on case management certification. In addition, case managers can contact the Case Management Society of America's fax-on-demand line at (877) 869-2672 to request a list of 20 case management certifications.] ■

Is your job description a certification roadblock?

Here's how to get back on track

Ever hear the expression, "Always a bridesmaid, never a bride?" The certified case manager (CCM) accreditation from the Commission for Case Manager Certification (CCMC) in Rolling Meadows, IL, may currently be the most widely recognized case management credential in the industry, but many experienced case management professionals find themselves relegated to the sidelines because their job descriptions make them ineligible to sit for the exam.

If you find yourself in this position, take heart — experts say many have successfully appealed and earned their right to sit for the CCM.

"If a case manager is found ineligible to site for the exam, they will get an explanation from the CCMC," notes **Carrie Engen Marion**, RN, BSN, CCM, president of Advocare / Triage in Naperville, IL, who was the first chair of the CCMC and is currently serving again as CCMC chair until May 2001. "They will also receive the information on how to appeal that decision and the due process that is available to all rejected candidates."

Many rejections are based on a finding that the candidate's job description does not clearly indicate that the case manager provides "care across the continuum," says Marion. "Case managers should take ownership of their job descriptions and make sure that what is in those job descriptions adequately describes what they do and if that description meets the needs of the CCM process."

Simple steps to success

The CCMC guidebook, Marion continues, clearly explains the eligibility requirements. It also clearly outlines the appeals process.

If you receive notification that you are ineligible to sit for the CCM, here are several strategies others in your position have used to successfully appeal their eligibility status:

• **Request a copy of the guidebook.** If you don't already have a CCMC guidebook, this is the time to request one and review it carefully,

(Continued on page 89)

Reports From the Field™

HIV/AIDS

Can your patients cope with HIV?

People infected with HIV are subject to ongoing stress. These patients are plagued with night sweats, nausea, medication side effects, and periods of physical disability. In addition, they may have to cope with unemployment, rejection by family and friends, hospitalizations, and the prospect of premature death.

It's not surprising that a recent study finds that coping strategies combined with social conflict and social support networks affect the psychological adjustment of HIV-infected individuals to their illness.

Researchers found that compared with perceived social support, social conflict was more strongly related to coping behaviors. Negative encounters with others — such as arguments, misunderstandings, and inappropriate demands — had a very strong effect on negative coping strategies including anger, social isolation, and withdrawal. Individuals who used social withdrawal as a coping mechanism were also found to have more negative moods and symptoms of depression. Researchers note that a dynamic may occur in which conflictual social interactions and social isolation aggravate each other and result in escalating psychological stress.

Older respondents coped more often than younger ones by seeking information and by engaging in positive actions, but they were also more likely to cope through isolation. Greater physical limitations were associated with more social isolation and fatalism. Feelings of HIV-related stigma were significantly related to coping with social isolation, anger, and cognitive avoidance, or trying to repress HIV-related concerns. Coping by seeking information was more strongly related to a positive mood than a negative mood.

[See: Fleishman JA, Sherbourne CD, Crystal S, et al. Coping, conflictual social interactions, social support, and mood among HIV-infected persons. *Am J of Comm Psych* 2000; 28(4):421-453.] ■

Men's Health

Searching for gold standard for chronic prostate care

Nearly 2 million American men suffering from prostatitis saw a physician for their condition between 1990 and 1994. The condition is characterized by pelvic area pain and lower urinary tract symptoms. The wide scope of recommended treatments for chronic prostatitis indicates how little is known about the causes, diagnosis, and treatment of the condition, leaving both patients and physicians confused and dissatisfied, according to a recent *Annals of Internal Medicine* article.

Acute bacterial prostatitis is straightforward to diagnose and treat, say researchers, adding that unfortunately bacterial prostatitis accounts for few cases of prostatitis. Chronic prostatitis is more common and more difficult to diagnose and

treat; 90% of all cases are abacterial and of unknown cause. In this study, researchers systematically reviewed studies from 1966 to 1999, contacted experts, and researched other sources to determine if there were reliable diagnostic tests or effective therapies for the condition.

The 19 diagnostic studies reviewed included 1,384 men between 33 and 67 years old. The 14 treatment trials reviewed included 570 men between the ages of 38 and 45 years old and involved the use of finasteride and alpha-blockers, anti-inflammatory medications, antibiotics, and thermal therapy.

Researchers concluded that there were no gold-standard diagnostic tests for chronic abacterial prostatitis, including the widely recommended bacterial localization tests, and that the quality of diagnostic studies was low. The treatment trials were conducted outside the United States and were methodologically weak, small in scope, and did not support the effectiveness of the medications studied. Thermal therapy appeared to have clinically significant benefit, say researchers.

[See: Collins MM, MacDonald R, Wilt TJ. Diagnosis and treatment of chronic abacterial prostatitis: A systematic review. *Ann Int Med* 2000; 133(5):367-381.] ■

Primary Care

Docs don't need more time, just awareness of patient 'clues'

Patients often provide two or three emotional clues during their physician visits regarding anxiety about their medical condition or psychological or social concerns that too often physicians miss.

A recent study of primary care physicians and surgeons shows that when doctors do respond to their patients' concerns, visits tend to be shorter, not longer. In other words, physicians can better respond to patient concerns even in the context of busy clinical practices.

Researchers analyzed audiotapes of 116 randomly selected routine office visits to 54 primary care physicians and 62 surgeons in community-based practices in 1994. They examined the frequency, nature, and content of patient clues during visits and physician responses to clues. They found that patients gave their doctors one or more clues during 52% of the primary care visits and 53% of the surgery visits, with a mean of 2.6 clues per visit in primary care and 1.9 in surgery.

Roughly 80% of the patient-initiated clues in primary care settings were related to psychological or social concerns in their lives, including aging, loss of a family member, and major life changes. More than half of the clues in surgical settings were also emotional in nature, with 70% related to patients' anxiety about their medical condition.

Researchers found that physicians responded positively to patient emotions in only 38% of cases in surgical settings and 21% in primary care. More frequently, physicians missed opportunities to adequately address patients' feelings. This is significant, they note, because many clinical studies suggest outcomes are better when physicians address patients' emotional concerns as well as their medical problems.

[See: Levinson W, Gorawara-Bhat R, Lamb J. A study of patient clues and physician responses in primary care and surgical settings. *JAMA* 2000; 284(8):1021-1027.] ■

PCPs don't take sleep seriously enough

Most primary care physicians don't ask patients questions about their sleep patterns even though lack of sleep is an important factor in many health problems, according to a recent survey from the National Sleep Foundation (NSF) in Washington, DC.

"The paradox happening in doctors' offices can be dangerous to patients' health," says **Richard L. Gelula**, executive director of the NSF. "While our survey finds that primary care physicians believe that sleep is important to personal health and should be an essential part of a regular checkup, they do not feel they can take the time to discuss it."

The telephone survey of 300 primary care physicians was conducted May 15 through July 7, 2000. Findings include:

• Nearly 70% of primary care physicians said they should raise issues about sleep with their patients.

• Roughly 80% said they are not as knowledgeable about sleep problems as they should be.

• More than 80% said availability of effective treatments and simple diagnostic tools would encourage them to prioritize sleep issues with their patients.

• More than 95% said the discussion is only likely to occur if the patient initiates it.

• Roughly 70% said discussing sleep issues takes time away from other medical problems.

Gelula speculates that physicians may be waiting for their patients to address sleep problems because they think the problems are less prevalent than American consumers report. Physicians said about 16% of their patients suffer from sleep disorders and 14% suffer from insomnia. However, the NSF 2000 Sleep In America poll found that 62% of adults surveyed experienced a sleep problem at least several times a week in the past year, and 58% reported symptoms of insomnia.

The NSF has prepared a simple guide, "Sleep Talk with Your Physician," to make it easier for patients to initiate sleep discussions with their primary care physicians. The guide is available on the NSF web site at www.sleepfoundation. org. ■

Geriatrics

New geriatric program reduces caregiver burden

The number of people providing assistance to an older relative or friend recently topped 21 million in the United States. Experts expect the burden on these caregivers to intensify as health systems shift more care to the outpatient setting and growing numbers of older adults strive to maintain their independence.

Researchers recently found that the outpatient geriatric evaluation and management (GEM) model, a new model of care delivery designed to reduce caregiver burden and nursing home admissions, does successfully deliver on its promises. In fact, only 17% of caregivers of older adults who received GEM care reported an increasing caregiving burden during the 12-month follow-up compared to 39% of caregivers of adults receiving usual care.

GEM begins with an intensive assessment of a frail older adult's medical, psychosocial, and functional capabilities by an interdisciplinary health care team. The team provides ongoing care tailored to the needs identified during the assessment.

In this study, the GEM team included a geriatrician, a nurse, a social worker, and a gerontological nurse practitioner. Researchers studied 568 high-risk, community-dwelling older adults and randomly assigned them to receive either GEM or usual care for six months.

The GEM team met with its assigned patients once a month and provided medical treatment, care management, educational information, counseling, assistance with advance directives, and referral to agencies and other professionals as needed. The team discharged the patient back to the primary care physician when the patient was adhering to the comprehensive plan of care or GEM team treatment goals were met.

In telephone interviews, researchers assessed at baseline and again at 12 months the burden experienced by the patients' informal caregivers. Questions included the overall time spent on caregiving and the extent to which caregiving disrupted their own lives.

[See: Weuve JL, Boult C, Morishita L. "The effects of outpatient geriatric evaluation and management on caregiver burden." *The Gerontologist*, 2000; 40(4):429-436.] ■

Managed Care

Physician incentives may reduce services

Managed care plans have developed complex and varied methods of contracting for physicians' services. Consumer advocates fear that some of these incentives may negatively impact the types of services patients receive.

Researchers recently surveyed more than 1,500 physicians under the age of 40 who had been in practice for at least two years but not more than nine years, to determine the self-reported impact of the overall influence of their contractual/compensation arrangements on the volume of services they provide to patients.

The following factors were significantly associated with an increased likelihood of physicians reporting an incentive to decrease services:

• a gatekeeper arrangement with financial incentives;

• perceived high risk of exclusion of physicians with high costs from the plan;

• the perception that referrals received depended on the costs of care provided;

• gag clauses forbidding disclosure of financial incentives to patients;

• receiving capitation payments from at least one plan;

• employment in an HMO.

Physicians who were compensated on a fee-for-service basis or receiving a salary with incentive or bonus provisions were more likely to report an incentive to increase services to patients. However, researchers found that physicians' overall methods of compensation had a relatively small impact on their perceived financial incentives compared to other factors.

The next step, say researchers, is to evaluate how physicians' perceptions of their financial incentives affect their behavior and care delivered to patients.

[See: Mitchell JM, Hadley J, Sulmasy DP, Bloche JG. Measuring the effects of managed care on physicians' perceptions of their personal financial incentives. *Inquiry* 2000; 37:134-145.] ■

HMOs don't always benefit from selection bias

Previous studies indicate that health maintenance organizations (HMOs) tend to attract healthier beneficiaries who tend to use fewer health services than patients attracted to fee-for-service plans. Naturally, HMOs benefit financially from this selection bias. However, a recent review of articles published after 1993 concludes that not all HMOs profit from selection bias. Researchers found that healthier patients are still more likely to join HMOs offered by Medicare and Medicaid programs, but not HMOs offered in the workplace. No selection bias was found in the employer-based insurance market so selection bias in the private sector does not result in overpayment.

Medicare HMOs attract healthier beneficiaries. However, Medicare rates were recently adjusted to include a health-based measure calculated using inpatient data. Medicare payments to HMOs were between 6% and 7% too high before the current diagnosis-based risk adjustment system that reduced payments by 7%.

Researchers note that because most states are moving toward mandatory Medicaid HMO programs, concern about the impact of selection bias on the appropriateness of Medicaid HMO payments is diminishing.

[See:Hellinger FJ, Wong HS. Selection bias in HMOs: A review of the evidence. *Medical Care Research and Review* 2000; 57(4):405-439.] ■

Behavioral Health

Drug therapy keeps depression away

Drug therapy effectively prevents relapse of major depression following electroconvulsive therapy (ECT), according to a recent study in the *Journal of the American Medical Association*.

Previous studies indicate that ECT is highly effective for treatment of major depression but that patients experience a high rate of relapse after discontinuation of ECT. A randomized, double-blind, placebo-controlled trial of 290 patients with unipolar major depression who had completed an open ECT treatment phase were included in this study. Of the 290, 159 patients met research criteria for relapsing depression after discontinuation of ECT. During the 24-week study, patients were randomly selected to receive placebo, nortriptyline, or a combination of nortriptyline and lithium. Findings include:

• The relapse rate for the placebo group was 84% compared to 60% for the nortriptyline group and 39% for the nortriptyline/lithium group.

• All but one instance of relapse in the nortriptyline/lithium group occurred within five weeks of ECT discontinuation.

• Relapse continued throughout the 24-week treatment period in the placebo and nortriptyline-only groups.

Researchers conclude that without active treatment virtually all patients relapse within six months of stopping ECT. Monotherapy with nortriptyline, they add, has limited efficacy.

[See: Sackheim HA, Haskett RF, Mulsant BH, et al. Continuation pharmacotherapy in the prevention of relapse following electroconvulsive therapy. *JAMA* 2001; 285(10):1299-1307.] ■

(Continued from page 84)

says **Peter Moran**, RN, BSN, MS, Cm, CCM, nurse case manager with Harvard Pilgrim Health Care in Wellesley, MA, and chapter president's representative for the Case Management Society of America (CMSA) in Little Rock, AR.

• **Review your job description.** If your job description does not adequately describe your case management duties, write a letter on company letterhead, have it signed by your supervisor and notarized, suggests Marion. The letter should state your job duties with an eye to the requirements in the guidebook.

"We recognize," says Marion, "that there may be problems with job descriptions, and have given individuals the ability to provide additional documentation. You as the candidate also must evaluate whether what you are doing is case management or another role with the title of case management. You have to then either change your case management program or job change your job title to more adequately describe what you are doing."

If a standard job description doesn't fit the bill, write a "day in my life" scenario, suggests **Anne Llewellyn**, RN-C, BPSHA, CCM, CRRN, CEAC, owner and independent case manager with Professional Resources in Management Education in Miramar, FL. "Think outside the box and write down examples of your daily work that support the things you say you do. Get your supervisor to sign it. We all do so much each day. Many of us think 'it's just part of my job, so it's not special.' Everything counts — as long as you can validate it."

The CCMC eligibility standards have been a catalyst for change in many case management programs, continues Marion. "A good example of this is occupational health nursing practice. Years ago, many occupational health nurses with traditional occupational health programs were found ineligible to sit for the CCM. Many programs changed to adopt a more case management focus within their organizations and the roles of the occupational health nurses expanded," she says.

• **Network with others in your practice setting.** "I advise professionals to contact other case managers in similar work settings, who have been allowed to sit for the exam," says Moran, "Ask for a copy of their job description."

Many home health and hospital-based case managers, Moran adds, have found that the simple acts of a follow-up telephone call and a preadmission assessment meet the requirement to provide "care across the continuum."

If a hospital-based case manager speaks to a home health agency to arrange care after discharge, checks up on the patient after they get settled at home, and talks to the physician who is following the patient during rehabilitation — they are working across the continuum, argues Llewellyn. "If they call themselves case managers, and they aren't doing those things — they should be!"

Sometimes, human resource departments within health care organizations fail to keep pace with current practice, notes **Jeanne Boling**, MSN, CRRN, CDMS, CCM, executive director of the CMSA. The best way to avoid eligibility roadblocks, she says, is for "case managers [to] assure their job descriptions are accurate prior to applying for certification."

Part of the job

Many hospital case managers do follow patients once they leave the hospital, agrees Marion. "The problem comes," she cautions, "when there is no follow-through and a large part of the case management process is missing."

Boling adds, "Case managers do not contribute to effective outcomes if they do not follow up on their work into the community to assess transition problems."

• **Lobby your employer to change your job.** The one thing case managers certainly should not do, stresses Boling, is inaccurately portray their job functions. She continues, "Case managers should be honest and describe exactly what they do. If what they do doesn't meet the accepted standards of case management, they should lobby to modify their jobs to meet the standards."

And, not everyone has to be a case manager. "I fail to understand the drive to have different jobs, such as discharge planning and utilization management, called case management," confides Marion. "I think what the CCMC's position is that episodic management in one isolated care setting is not serving the needs of the patient very well or providing for any consistent care. I think all case managers should, as much as possible, do care across the continuum. I think case management has a specific body of knowledge, including the process of case management, and anything that does not include that process should be called something else." ■

Resources help you take action now

Here's how to ease the nursing shortage

The nation's health care delivery system is staggering under the weight of patient unrest over managed care policies and an impending nursing shortage that threatens to strike right at the heart of the quality of direct patient care. Several health care professional associations and publishing groups have stepped up to the plate and developed resources to help define and address the problems facing health care in America — including the pressing issue of how to retain and recruit qualified nurses.

1. COR Health in Santa Barbara, CA, recently released *Nurse Recruitment & Retention Strategies 2001* — a compendium of best practices in nurse recruitment and retention edited by Deloras Jones, RN, MS, designed to help health care organizations develop strategies to maintain quality patient care in an increasingly tight labor market.

Topics covered in this resource include:

- building and sustaining an optimal workforce during the coming nursing shortage;
- successful nurse recruitment efforts in the past three years;
- key benefits nurses are looking for;
- how a consortium of providers collaborated to develop their own specialty-trained nurses;
- the impact of recruitment and retention efforts on patient outcomes and the bottom line.

The book costs $189. For more information, visit www.corhealth.com\nrrs.html.

2. The American Organization of Nurse Executives (AONE) in Washington, DC, has published several resources to help define the impact of the nursing shortage and to help organizations fight back.

AONE initiated the *Nurse Recruitment and Retention Study* in 1999. This exploratory study includes interviews with 58 nursing and human resource administrators nationwide at community and academic acute care hospitals. It presents practical information on approaches to finding and retaining qualified nurses. The report costs $75 for non-AONE members and $35 for members. Request #WS-154301.

Perspectives on the Nursing Shortage: A Blueprint for Action is an AONE monograph to help nurse executives, health care administrators, and others understand federal, state, and regional policies related to the nurse workforce. The monograph provides a national overview of the problem, as well as analyses of unique state, regional, and local situations. It also includes information on current federal, state, and regional nursing workforce legislation and recommendations for national and state policy makers.

Issues covered include:

- national trends in employment and earnings of nursing personnel;
- the current nursing shortage;
- the impending shortage;
- recommendations for reversing the shortage.

The 75-page monograph costs $80 for non-AONE members and $45 for members. Request #WS-154195.

A companion piece to the monograph above, "Discussion Toolkit for Perspectives on the Nursing Shortage: A Blueprint for Action," is designed to assist nurse leaders in explaining and discussing the nursing shortage within their organizations and their communities. Each packet includes a Microsoft PowerPoint presentation, overheads, speakers' notes, discussion questions, and the executive summary of the monograph.

The kit costs $40 for non-AONE members and $30 for members. Request #WS-154196.

3. The Institute of Medicine of the National Academies in Washington, DC, recently released *Crossing the Quality Chasm: A New Health System for the 21st Century.*

The report makes several recommendations to redesign and improve the quality of health care in the United States.

Recommendations include:

- Provide care based on continuous healing relationships, or 24-hour care delivered over the Internet, telephone, and other means, as well as face-to-face.
- Decision making should be evidence-based.
- Information should be transparent to patients and families.
- Patients should have free access to their own medical information.
- Patients should be the source of control over health care decisions that affect them.
- Patient safety should be ensured.
- System waste should be reduced.

The 300-page report costs $44.95 plus shipping and handling. To order, call (800) 624-6242. The report can also be read on-line at www.nap.edu.

Once on the web site, type "chasm" in the search title box.

4. A coalition of nursing associations, which includes the American Nurses Association and the American Organization of Nurse Executives, both based in Washington, DC, banded together as the Tri-Council to propose changes and enhancements to the education, work environment, legislation and regulation, technology, research data and collection currently aimed at attracting and retaining nurses.

The Tri-Council's white paper, *Strategies to Reverse the New Nursing Shortage*, first defines the nursing shortage citing numerous studies in the literature and data from state and federal sources, and then suggests strategies to address and reverse this troubling trend.

Tri-Council recommendations include:

• motivating nurses to seek higher education through career progression initiatives;

• redesigning work to allow older nurses to remain active in direct care roles;

• compensation tied to education and the promotion of staff development programs;

• advocating for increasing nursing education funding under Title VIII of the Public Health Service Act and other publicly funded initiatives;

• investigating the potential for using technological advances to enhance the capacity of a reduced nursing workforce.

More information on the white paper is available on the web sites of the participating organizations including www.ana.org, www.nln.org [the New York City-based National League for Nursing], and www.aone.org. ■

URAC launches web site accreditation

Patients now have added layer of protection

Case managers whose patients turn to health web sites for sensitive medical information are often concerned that these sites may not do an adequate job of providing accurate health information or protecting patient privacy. In an attempt to better safeguard consumers seeking health information on the Internet, URAC/ American Accreditation HealthCare Commission in Washington, DC, recently launched a Health Web Site Accreditation program as part of its ongoing commitment to set quality standards for health care organizations.

URAC also encourages case management organizations who launch their own health web sites and turn to the Internet to provide patient education and management services to seek accreditation, as well. It's a mark of quality that often translates into consumer confidence and trust.

"Many URAC-accredited companies have found that accreditation is a mark of distinction that gives them a competitive advantage in the marketplace," says **Gary Carneal**, JD, MA, URAC president and CEO. He continues, "We feel that this advantage will be especially important in the e-health space, because it is so consumer-oriented and consumers want assurances that they are receiving quality health information and services."

URAC released a draft of the health web site standards for public comment in late February and accepted comments from interested parties until April 23. Now, URAC's Health Web Site Advisory Committee is reviewing the comments and revising the draft standards. URAC plans to begin testing the proposed standards on several pilot health sites and hopes to adopt final standards in July.

Organizations interested in reading the proposed health web site standards or submitting a pre-application for Health Web Site Accreditation should visit the URAC web site at www.urac.org for details about the terms and conditions of the accreditation process and to complete the pre-application form, or call URAC at (202) 216-9010. Interested parties may also e-mail businessdevelopment@urac.org to request more information. ■

Managed Care/News Briefs

Health plans seek relief from complicated RFIs

Employers agree process must be simplified

Employers have joined the nation's health plans to simplify the way they evaluate health plans' requests for information. New guidelines released by the American Association

of Health Plans (AAHP) and the Employers' Managed Health Care Association (EMHCA) both based in Washington, DC, should reduce costs for employers and health plans while at the same time improving the data used to select health plans.

Data collection is an expensive process, yet one health plan recently reported receiving an RFI requesting 220,000 data points, according to AAHP. To make matters worse, only about 10% to 15% of questions are common to multiple RFIs.

"Especially at a time of great concern about health care costs, we had to find a better way to get in-depth health plan data that would be less costly and less burdensome to plans and employers alike," explains **Dwaine Hartline**, EMHCA's board president.

The new guidelines have already received wide support from business leaders and benefits administrators, report the sponsoring organizations. The result should be to produce information that can better compare plans, while dramatically reducing costs spent to prepare and analyze such data.

The guidelines address the following four areas:

- clarifying and moving to standardized questions;
- avoiding duplication and repetition of questions in various stages of the contracting process;
- using HEDIS [Health Plan Employer Data and Information Set] measures to promote standardization;
- providing requests electronically or in other easy-to-use formats.

More information on the new guidelines is available on the organizations' web sites at www.aahp.org and www.emhca.org. ▼

URAC receives nod from Ohio Workers' Comp

Only accredited MCOs will get contracts

Notice: If you want to do case management for the Ohio Bureau of Workers' Compensation (BWC) in Columbus, you must be accredited by the URAC / American Accreditation HealthCare Commission in Washington, DC, by the end of 2002.

BWC, which is both the regulator of workers' compensation and the administrator of the state risk-pool for injured employees, now requires managed care organizations (MCOs) it contracts with for medical management and return-to-work services to receive URAC's Case Management Organization Accreditation. In a new contract sent to more than 30 MCOs, the BWC advised them to "apply for URAC case management accreditation no later than Dec. 31, 2001" and to "use [their] best efforts to obtain URAC case management accreditation no later that Dec. 31, 2002."

"One of the advantages we see in having our MCOs URAC-accredited," notes BWC representative **Diana Cline**, "is that it's an independent accrediting body reviewing our MCOs' case management programs, which Ohio views as critical in providing quality services for our injured workers. An independent review is very important to us."

For more information, contact Cline at (614) 466-8269, or e-mail her at dianna.c.1@bwc.state.oh.us. ▼

AMA says, 'HMOs must be accountable'

Patient bill of rights still topic of debate

The debate over passage of a patient's bill of rights still rages and case managers in managed care plans should pay close attention to the anti-managed care rhetoric of health care advocates as they lobby legislators to ensure their interests are well represented when the final draft becomes law. During recent hearings on Capitol Hill, officers of the American Medical Association (AMA) in Chicago told Congress that HMOs, like every other entity in our society, must be held accountable for harm they do to patients.

"It simply isn't fair to grant a shield of immunity to health plans — a shield not given to any other person or business entity," argued AMA trustee **Donald J. Palmisano**, MD, before the House Energy and Commerce Health Subcommittee.

The majority of Americans seem to agree with this sentiment. A January Kaiser / Harvard poll found that 75% of Americans support patient

protections, including the right to sue health plans. "There is no sound policy reason why we should leave injured patients with no real legal remedy when they have been injured by a negligent health plan," Palmisano told House subcommittee members. "This is truly an issue of fundamental fairness."

Federal judges also have called on Congress to fix the problem, Palmisano said, noting that "because states historically have retained jurisdiction to govern the practice of medicine, if the case involves a medical judgment the plan has made, then the case should go to state court. It's that simple."

The Judicial Conference of the United States, headed by Chief Justice William Rehnquist, has urged Congress to use state courts as "the primary forum for the resolution of personal injury claims arising from the denial of health care benefits."

Palmisano urged Congress to pass a strong patients' bill of rights, saying "President Bush has stated repeatedly that the patient protection laws in Texas are working well. Despite the insurance industry's claims, health care costs have not skyrocketed; employers have not suddenly dropped health benefits; and patients trying to file frivolous lawsuits have not overrun the courts. We (the members of the AMA) call on Congress to help pass a meaningful, bipartisan patients' bill of rights this year." ■

Docs want independent appeals, not lawsuits

Poll finds patients, docs agree

Patients, employers, and physicians have found some common ground, according to a recently released poll from the American Association of Health Plans (AAHP) in Washington, DC. It seems all three groups prefer an independent medical appeals process over lawsuits as a means of resolving disputes over medical coverage.

In addition, the poll of 400 physicians finds that America's physicians think the medical liability system has damaged the practice of medicine. In particular, physicians report that the current liability system raises medical costs, hurts the doctor-patient relationship, leads to defensive medicine, and reduces the reporting of medical errors.

Specific findings include:

- 75% of physicians favor giving an independent physician appeals panel the power to resolve disputes with health plans over coverage, whereas 17% prefer to give patients the option to sue their health plans for damages.
- 73% of physicians prefer a bill with an independent appeals process compared to 20% who believe that no bill should be passed unless new lawsuits are included.

The results of the physician poll mirror those of a poll of 1,000 voters conducted last November by AAHP. A copy of the survey in PDF format is available on-line at www.aahp.org/aahp/redirect/summary.pdf. ■

Behavioral Health

Standard definitions lead to better data

NAPHS calls for consensus

Standardized performance measures would go a long way toward helping case managers select appropriate behavioral health providers for their clients. And, although behavioral health care providers seem willing to create industry-wide core performance measures, a recently released white paper from the National Association of Psychiatric Health Systems (NAPHS) in Washington, DC, finds wide variation in the way key benchmarking indicators are defined and collected.

Individual behavioral health facilities collect large quantities of data within their own organizations, reports NAPHS. However, a pilot test of key benchmarking indicators by NAPHS found that substantial challenges remain in gathering, reporting, and comparing data across systems.

The pilot project was coordinated by the NAPHS Benchmarking Committee, chaired by NAPHS Immediate Past President Peter Panzario, MD, chairman of the department of psychiatry at Cedars Sinai Medical Center in Los

Angeles. The pilot, which focused on nine indicators chosen from an earlier consensus-driven process of the committee, analyzed data from 48 facilities offering a total of 637,241 inpatient days; 601,595 residential care days; and 161,993 partial hospital days. The facilities represented all levels of care including inpatient, residential, partial hospitalization, and outpatient services and all populations including children and adolescents.

Indicators reviewed were:

- adverse drug reactions;
- completed suicide;
- attempted suicide;
- restraint;
- seclusion;
- symptom/function measure;
- readmission;
- patient satisfaction;
- peer review.

In its report, *White Paper: Lessons Learned from Pilot Testing of the NAPHS Benchmarking Indicators*, the organization outlines challenges identified in the testing phase and provides commentary on each indicator in the pilot test.

According to the white paper, data comparison efforts are hampered due to wide variation in definitions of key indicator terms used by different facilities. For example, there was great variation, says NAPHS, in the definitions of restraint and seclusion, particularly as they related to children and adolescents. Reporting mechanisms appear to be in place in all facilities for collecting data about restraint and seclusion, the report's authors note, stressing that if the field can agree on consistent definitions, the possibility for developing meaningful benchmarks seems strong.

Similarly, the definition of attempted suicide used in this pilot test shows how difficult it is to standardize definitions, the report notes. The wide variation in incidents reported indicates that some facilities reported incidences that were not of the severity of the operational definition used in the pilot, according to the report.

"As this pilot test demonstrates, there is high interest and commitment by behavioral health providers to work toward core performance measures that will help organizations improve the quality of care and be responsive to the needs of those who seek mental health care," says **Mark Covall**, executive director of NAPHS. "We have learned a great deal about the importance of focusing on data that is relevant to clinical operations and collected in ways that conserve limited resources."

White Paper: Lessons Learned from Pilot Testing of the NAPHS Benchmarking Indicators costs $40 prepaid. To order, contact NAPHS, 325 Seventh St., NW, Suite 625, Washington, DC 20004. Telephone: (202) 393-6700, Ext. 15. Or, visit the NAPHS web site at www.naphs.org. ■

Disability Management/News Briefs

Single-dose drug provides superior pain relief

Study finds COX-2 better than morphine

Researchers found that a single dose of injectable COX-2 specific analgesic provides superior pain relief for total knee replacement patients, according to results of a Phase III study presented at the recent American Academy of Orthopaedic Surgeons Annual Meeting in San Francisco.

The multi-center, double-blind, placebo-controlled study included 208 patients with moderate to severe post-surgical pain. After discontinuing patient-controlled analgesia on the first post-surgical day, patients were randomly assigned to receive either:

- a single intravenous dose of parecoxib sodium (COX-2, 20 mg or 40 mg);
- ketorolac (30 mg);
- morphine sulfate (4 mg);
- placebo.

Additional analgesics, or rescue medications, were administered as needed, and pain and safety were assessed over the next 24 hours.

Researchers found that parecoxib sodium, ketorolac, and morphine sulfate each had a similar onset of action with a median time of 11 to 15 minutes. However, patients treated with the 40 mg dose of parecoxib sodium continued without additional analgesics significantly longer than patients treated with morphine sulfate.

Specific time until patients requested additional analgesics were:

- Parecoxib patients had a median duration of five hours and 10 minutes prior to requesting

additional analgesics.

• Morphine sulfate patients had a median duration of two hours and seven minutes prior to requesting additional analgesics.

• Ketorolac patients had a median duration of four hours and 35 minutes prior to requesting additional analgesics.

In addition to longer median duration of pain relief, 80% of patients who received the 40-mg dose of parecoxib rated their pain medication as good or excellent compared to 70% of ketorolac patients and 45% of morphine patients.

"Total knee replacement is a very painful procedure," **Evan Ekman**, MD, an orthopedic surgeon and director of Southern Orthopaedic Sports Medicine in Columbia, SC, told attendees. "Keeping pain in check following knee replacement surgery can be very challenging, given the side effects of analgesics like morphine and ketorolac," he noted. "This study suggests that parecoxib may become an effective and well-tolerated option, which is an exciting prospect, since no new injectable analgesics have been introduced in the United States in more than a decade." ▼

Technology improves knee implants

Implants last longer, say researchers

Active, younger patients who suffer from arthritis or chronic injury may soon have access to knee replacement surgery much earlier in life, thanks to a new implant technology introduced at the recent American Academy of Orthopaedic Surgeons Annual Meeting in San Francisco.

Orthopedic surgeons have traditionally delayed joint replacement surgery in patients younger than 65 because the implant materials used rarely withstood the wear placed on them for longer than 10 to 15 years. Smith & Nephew's Orthopedic Division in Memphis has developed oxidized zirconium — a metallic alloy with a ceramic surface — in response to the orthopedic community's concerns over implant wear. The U.S. Food and Drug Administration in Rockville, MD, recently approved oxidized zirconium for use in knee implants.

"Oxidized zirconium addresses one of the most critical issues in clinical orthopedics today, which is the generation of wear debris," notes **Leo Whiteside**, MD, of the Missouri Bone and Joint Center in St. Louis. "The bottom line is the lower the amount of wear debris generated, the longer the implant will last."

Most implants on the market are made from a cobalt-chrome alloy that slides against a plastic bearing. The motion and friction caused by daily living can damage the implant's surface and cause metal and plastic wear debris leading to bone loss and the need for replacement implants. Compared to cobalt chromium oxidized zirconium, in knee wear simulation testing, reduced the rate of plastic wear by 85%.

"We've been evaluating the new knee implant

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Editorial Questions

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

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Production Editor: **Nancy Saltmarsh**.

in patients for the past two years," says **Richard Laskin**, MD, of the Hospital for Special Surgery in New York City. "The exciting part is that this is not an externally applied coating. The metal component is heated and infused with oxygen until the outer surface naturally turns into a ceramic."

Implants made of oxidized zirconium also contain nondetectable traces of nickel, providing a solution for the more than 20,000 candidates for total knee replacement each year identified as acutely allergic to nickel.

For information on product availability by region, visit the company web site at www.oxidizedzirconium.com. ■

■ New Drug Update ■

FDA approves new type-2 diabetes drug

Novartis Pharmaceuticals in East Hanover, NJ recently received approval from the U.S. Food and Drug Administration in Rockville, MD, for Starlix (nateglinide), the first D-phenylalanine derivative. Starlix has been approved as both initial monotherapy and in combination with metformin in patients with type 2 diabetes whose blood glucose is not controlled by exercise and diet.

Starlix stimulates rapid, short-acting insulin secretion that reduces the mealtime increase in blood glucose levels or spikes, and effectively lowers overall blood sugar levels as measured by HbA1c.

In a 24-week, randomized, double-blind, placebo-controlled study of 701 patients with type 2 diabetes, researchers found that Starlix alone effectively controlled mealtime glucose spikes and reduced overall glucose levels as measured by HbA1c. In the same study, researchers found that the combination of Starlix and metformin was complementary and resulted in even greater reductions in HbA1c than either agent alone.

For further information, visit www.novartis.com, or call (877) 782-7549 for prescribing information. ■

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*

Free report helps you keep step with HIPAA

Atlantic Information Services (AIS) in Washington, DC, recently launched the *Report on Patient Privacy* to address the complex issues of protecting the privacy and confidentiality of patient medical information under the final Health Insurance Portability and Accountability Act (HIPAA) privacy rule.

The first issue of the publication included these topics:

- how much patient information clinicians can share with each other as they discuss diagnoses and map treatment strategies;
- challenges for hospitals, and health maintenance organizations posed by the final HIPAA rules;
- questions raised by the interaction of HIPAA, state laws, court actions and contractual restrictions;
- cautionary advice for clinical researchers;
- identifying gaps in current practices and practices mandated under HIPAA.

To receive a free copy of the *Report on Patient Privacy*, call AIS customer service at (800) 521-4323. In addition, AIS is cosponsoring an on-line HIPAA compliance discussion group with eCompliance.com, an Internet portal that brings together information, products, and services for health care compliance. The free discussion group is designed to help health care professionals exchange ideas and information on HIPAA-related issues. The site is located at www.eHIPAAcompliance.com. ▼

Resource helps patients understand their pain

Pritchett & Hull in Atlanta recently released "Pain Management" tearpads that help health care organizations meet the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations' 2001 pain management standards.

One side of the pain management tearpad provides patients with tips for identifying and managing pain. The other side provides a pain scale and a useful chart for tracking pain and the treatments used to control it.

In all, Pritchett & Hull has released 26 new tearpad titles for 2001. The 8 ½ x 11," double-sided tearpads cost $10 for a pad of 50. For the "Pain Management" tearpad, request item #362.

Other new titles include:

- "Cardiac Catheterization" (#370);
- "CHF and Blood Pressure" (#369);
- "CHF and Exercise" (#366);
- "CHF and Weight" (#368):
- "CHF Learning" (#367);
- "Stents" (#363);
- "Diabetes Diary" (#355);
- "Understanding Type I Diabetes" (#333);
- "Understanding Type II Diabetes" (#334).

Samples of all Pritchett & Hull tearpads can be viewed on-line at www.p-h.com. To order, contact Pritchett & Hull, 3440 Oakcliff Road, NE, Suite 110, Atlanta, GA 30340-3079. Telephone: (800) 241-4925. Fax: (800) 752-0510. ▼

Baxter launches renal education program

Baxter Healthcare in Deerfield, IL, recently launched "Stay in Touch," an integrated education initiative for people at risk for or diagnosed with kidney disease. The education program offers case managers and nurse educators an Internet-based tool, a toll-free hotline and a series of customized educational mailings that are timed to a patient's progressive needs.

The integrated approach is designed to help meet the needs of kidney patients as they struggle to understand their disease and make informed decisions about their care. Internet-based education is available at www.kidneydirections.com. The Web site gives patients

convenient access to customized tools and information resources. Case managers and nurse educators can also use the site to deliver education to their patients. The site was developed by a medical advisory board with expertise in kidney disease.

The "Stay in Touch" educational mailing program was piloted last year in six states and is now available nationwide. This outreach initiative brings education right to the patients' doors, offering resources that provide insight into the progression of the disease and its impact on patients' lives. The goal of the mailing program is to promote earlier diagnosis and referrals to appropriate specialists and help patients make positive, long-term adjustments to their lifestyles.

The program is augmented by kidney patient educators who are available in areas with high concentrations of people with kidney disease. Baxter has already provided individualized education through nurses to more than 21,000 patients nationwide through referrals by more than 900 physicians. The nurses educate patients about kidney function, kidney failure, and the various treatment options.

People who are at risk or have been diagnosed with kidney disease can enroll in "Stay in Touch" by calling (888) 233-6651, or by registering online at www.kidneydirections.com. Case managers may also register their patients in this program using the same contact information. ▼

Order free caregiver survival kit from NFCA

Novartis Pharmaceuticals in East Hanover, NJ, and the National Family Caregivers Association (NFCA) in Kensington, MD, recently teamed up to create the "Caregiver Survival Kit" for the family and friends of Alzheimer's patients.

The kit includes the following resources:

• a copy of NFCA's newsletter, *Take Care!*, which provides advice and resources for caregivers;

• several NFCA educational pamphlets designed to help caregivers take better care of themselves;

• an educational video featuring actress and television personality Linda Dano that covers diagnosis, treatment, and caregiving;

• a brochure written by Dano in which she shares her caregiving experiences during the three-year period she cared for her father as he suffered with Alzheimer's.

Case managers may order the free kit for the family and friends of their Alzheimer's patients by calling (877) 439-3566, or on-line at www.nfcacares.org.

NFCA educates, supports, and advocates for the estimated 25% of American adults who care for their ill, aged, or disabled loved ones. The organization addresses the common needs and concerns of all family caregivers — not just those caring for Alzheimer's patients. More information on the organization and its resources is available on the NFCA web site at www.nfcacares.org. ▼

Annual report finds organ donations down in '90s

The gap between organ transplants and the number of patients waiting for an organ transplant more than doubled in the 1990s, according to a report prepared by the United Network for Organ Sharing (UNOS) in Richmond, VA.

Between 1990 and 1999 the number of Americans waiting for organ transplants more than tripled from 21,914 in 1990 to 72,110 at the end of 1999, according to the recently released *2000 Annual Report of the U.S. Scientific Registry* of *Transplant Recipients* and the Organ Procurement and Transplantation Network. Annual cadaveric and living donor transplants increased at a much slower rate, going from 15,009 in 1990 to 21,715 in 1999. ■

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. ■