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# Case Management ADVISOR™

*Covering Case Management Across The Entire Care Continuum*

## INSIDE



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Reports From the Field/Resource Bank

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# Effective telemanagement: Developing a solid game plan keeps calls on track

*Here's how to get the data you need in 20 minutes or less*

Telemanagement is a cost-effective tool for monitoring the health of chronically ill patients and avoiding preventable complications that land patients in the hospital or emergency department. Unfortunately, many case managers find that it's difficult to keep patients on track during televisits.

**Lorraine Deschaine**, RN, LSW, case manager with Northern Maine Medical Center in Ft. Kent, ME, works a 30-hour week as case manager for a community outreach program that targets congestive heart failure (CHF) patients and others in need of disease management in the outpatient setting. "I have about 50 patients I'm working with at this point. I need to keep my telephone visits to no more than 15 or 20 minutes, or I'll never be able to keep up with my caseload."

Deschaine and **Donna Zazworsky**, MS, RN, CCM, director of home health and outreach for St. Elizabeth of Hungary Clinic in Tucson, AZ, and principal of Case Manager Solutions, an independent case management company with offices in Tucson and New York City, say the key to controlling televisits is to have a game plan that includes the following:

**1. Set the ground rules.**

Deschaine begins educating patients while they are still hospital inpatients, or through the mail for patients who are referred to her through their physician's office. "I cover the important things they need to know about their diagnoses and call them the day after discharge to review their medications and the signs and symptoms of complications, as well as preventive measures," she says. "I also provide them with written materials, checklists, weight logs, or glucose logs — whatever information I need them to track in order for me to help them manage their particular disease."

In addition to providing patients with written materials, Deschaine uses a yellow highlighter to emphasize issues of particular importance to specific patients. "I highlight issues I want patients to pay special

attention to, and I draw their attention to those highlighted areas during televisits," she says. "So when I call, they are prepared and that's a big factor in keeping the calls on track."

**2. Schedule the televisit.**

Organization must be a high priority for any case manager developing a telemanagement program, Deschaine stresses.

One way to stay on track is always to schedule your televisits with the patient, suggest Zazworsky and Deschaine. "I schedule six calls a day," Deschaine says. "And I start in the morning with the most acute patients. In that way, if there is a crisis, I can allow extra time for the call and reschedule calls with more stable patients for the next day. I never want to overschedule and risk rushing a patient in crisis," she adds. "It's important that you build some flexibility into your schedule."

It's also important to schedule calls at the best time for your patient, Deschaine notes. For example, some people are late risers and shouldn't be scheduled for early morning meetings. "They won't be ready for you, and you'll waste time while they look for the folder with the materials you want to cover."

She suggests that case managers tell patients what day they plan to call and allow the patients to select the time of day that works best for them. "This way when you call, they have their documentation ready, and the call progresses smoothly."

**3. Avoid open-ended questions.**

"The telemanagement program I worked with was for seniors with congestive heart failure. The nurses who asked open-ended questions quickly ran into trouble, because seniors want to talk," she notes. "Don't ask, 'What did you eat yesterday?' or they will begin to recite everything they had from the moment they got out of bed. Instead, ask what they had for dinner."

**4. Set up a documentation system.**

No case management program can survive without evidence that its interventions improve clinical and financial outcomes, Zazworsky cautions. "You must have objective data that can be collected and reported if you want to prove your program works and ensure that funding for it is continued."

Deschaine works with a quality improvement staff member at Northern Maine Medical Center to track the progress of patients in her program. For each patient, Deschaine collects utilization data for the six months immediately prior to case management and the six months after initiation of case management.

For the 18 patients who have been enrolled in the telemanagement program the longest, the results look very promising, she notes. These include:

- Total number of hospital admissions for the 18 patients decreased from 33 hospitalizations in the six months prior to case management to 18 admissions in the six months after beginning case management.
- Total number of hospital inpatient days decreased from 146 days in the six months prior to case management to 84 days in the six months after beginning case management.
- Total number of emergency room visits decreased from 19 in the six months prior to case management to eight in the six months after beginning case management.

**5. Listen carefully.**

Naturally, televisits have some limitations, but even those can be overcome with practice, Deschaine notes. "I can't read body language over the phone. However, I really listen to each patient's voice and familiarize myself with their normal tone."

If a CHF patient appears short of breath, Deschaine often "measures" the degree of breathlessness by sending the patient into another room. "I may have a patient tell me he's short of breath, but 'it's no big deal.' To assess whether or not the shortness of breath is an issue of concern, I may ask the patient to go weigh himself. I know the bathroom is down the hall and that to weigh himself, the patient will have to walk down the hall to the bathroom and back. When he returns, I listen to his breathing."

And just because you don't work with your patients "face to face" doesn't mean you won't

develop a relationship with them, says Deschaine. She recalls one patient who had been referred through his doctor's office. "We had never met, but I sent him literature in the mail and conducted regular televisits with him." About six months after he had been admitted to case management, the patient was hospitalized for an acute CHF exacerbation.

"When we finally met in the hospital, the minute he realized who I was, he turned to the person visiting him and said, 'Oh, this is my nurse.'" Deschaine adds that in the six months prior to case management the patient had been admitted almost monthly. ■

# Good publicity can support CM initiatives

*Put the media to work for you*

Nursing and politics not only mix, but if you can find a way to focus the media spotlight on what matters to you and those you represent, sometimes you can make wonderful things happen. Just ask **Donna Zazworsky**, MS, RN, CCM, director of home health and outreach for St. Elizabeth of Hungary Clinic in Tucson, AZ; principal of Case Manager Solutions, an independent case management company with offices in Tucson and New York City; and "Nurse Donna" to television viewers across Arizona.

It wasn't long ago that a local bond issue in Tucson to improve the parks and recreation department faced defeat at the polls. "I was reading the Letters to the Editor in the local paper and I could tell that many residents were confused about the bond and what it would provide," she recalls. "In fact, many groups were opposed to the bond due to some misinformation about the adaptive recreation center included in the plan."

Zazworsky had been working for several years on a successful multiple sclerosis (MS) management program that included regular water exercise. "The bond issue called for an adaptive aquatics center to make it easier for MS patients to participate in the benefits of water exercise. Unfortunately, local residents feared that the new center would take away from existing facilities at the park in question."

The solution was a news story that not only included an architect's model of the new center but also brought the mayor and city council members to the site to discuss the importance of the bond issue. Zazworsky also appeared in the story, accompanied by images of her arthritis and MS patients exercising in the pool. "We talked about the benefits of water exercise and the need for a special recreation center for adaptive needs. We clarified that the new center would replace the old, outdated center and not take space away from the park."

The piece on the recreation center and the benefits of water exercise aired three days before the bond vote, and the bond passed.

### *Attracting attention*

You don't have to be "Nurse Donna" to get your own stories to the attention of the public through the media, says Zazworsky.

Here are four strategies she says will help you get your message out:

**1. Develop a relationship with local media.**

"You must develop a relationship with local reporters," she stresses. "You want to align yourself with a reporter who is going to hear your voice above all the others competing for their attention."

Zazworsky suggest that you read local papers, watch local news broadcasts, and take note of the reporters who regularly cover health and medical news. "Most newspapers run their reporters' e-mail addresses right under their byline," she notes. "Start a correspondence with the reporter if they are covering an issue of concern to you. Let the reporter know you have useful information on diabetes or congestive heart failure that you would be glad to share."

However, she cautions, reporters get dozens of e-mails each day from individuals just like you. "You have to find a message that will make you stand out from the rest — a new approach to the issue."

**2. Identify "hot topics."**

"You will always get a reporter's attention if you can contribute to a theme already in development," Zazworsky says. "For example, if a television reporter announces a four-part series on heart disease, call and let him know about your heart disease management program. Tell him you have someone available to talk about it if he is interested."Another approach is to watch for "hot topics" and suggest a news story that relates to it, Zazworsky suggests. For

example, if there is a story in the news about an elderly woman with Alzheimer's disease wandering away from a local nursing home, call and suggest a story on Alzheimer's disease and management skills for families.

**3. Always follow up.**

"If you e-mail a reporter with an idea and don't hear back, e-mail again," Zazworsky stresses. "You absolutely must follow up. These people are very busy and they receive many communications each day. You can't just send one message and give up if you don't get an immediate response."

**4. Be ready to deliver.**

Never suggest a story without being able to deliver the appropriate individuals for interview, she cautions. "I had a friend who had what I thought was an excellent story idea. The story involved children. I knew the television station would want a child to interview. It took my friend too long to find the right child, and the opportunity was lost. Timing is essential. You've got to be ready, now!"

Most important, Zazworsky notes that you must develop a sense of "what is newsworthy." If you can develop that news sense and build a relationship with local reporters that makes you the person to call about health issues, the media can be a powerful ally that supports your efforts to provide services for your patients. ■

# Report claims media hamper research

*Media portrayals cause confusion, fear*

Lifesaving medicines needed by some 60 million Americans result directly from the 50,000-plus clinical trials conducted annually in the United States. These trials depend on a rapidly increasing pool of volunteers to confirm the safety and efficacy of new therapeutics and procedures.

Nearly 2.8 million Americans voluntarily participated in clinical trials in 1999. Now, a white paper released at the Association of Clinical Research Professionals (ACRP) meeting in San Francisco claims that negative portrayals of clinical research in the media are causing Americans to turn their backs on the opportunity to participate in research studies.

The white paper includes the results of the 2001 ACRP survey in which more than 700 of the association's members identified both positive and negative attitudes shaped by the media. Less than 33% of respondents felt that the media are fair in their portrayal of the clinical research industry. Less then 50% felt that the media provide a "good public service" when reporting on clinical research. And more than 75% agreed that "media reporting about clinical research has created confusion and fear among the public."

"Although there are isolated instances of investigator fraud or financial conflicts improperly influencing investigators, those instances are the exception rather than the rule," argues **James W. Maloy**, PharmD, the study's lead author. "The media concentrate on the exceptions, the negatives, rarely on the positives. I'm afraid that the media treatment of the industry is resulting in more people becoming unwilling to volunteer for clinical trials."

Statistics reported in the white paper confirm that a growing number of studies may not be able to go forward without a dramatic increase in the ranks of willing clinical trial participants.

More information on the white paper is available at www.acrpnet.org. ■

# Consumers worry as health costs rise

*39% say they know nothing about managed care*

Health care costs continue to rise while access to health care continues to decline — a combination that has made many Americans increasingly critical of some aspects of the health care delivery system, according to a new study by the Employee Benefit Research Institute, a Washington, DC-based public policy research organization.

Perhaps the most surprising finding of the 2000 Health Confidence Survey is that, at a time when industry data indicate 90% of American workers are participating in managed care plans, only 10% of survey respondents report believing that they currently are enrolled in a managed care plan. Another 11% report they believe they previously were enrolled but currently are not, and another 11% are not sure whether or not they

have ever been enrolled in a managed care plan. Further, more than 66% of Americans surveyed report believing they have never been enrolled in managed care.

The percentage of respondents who describe themselves as "somewhat familiar" with managed care dropped from 29% in 1998 to 23% in 2000. Similarly, the percentage of Americans who report being "not at all" familiar with managed care increased from 28% in 1998 to 39% last year.

While 25% of Americans are "extremely confident" or "very confident" of their ability to afford health care without hardship during the next 10 years (up slightly since the 1998 survey), many respondents, particularly women and those in poorer health, express concern about escalating health care costs and a lack of confidence in their ability to afford medical expenses in the future.

Specific findings include:

• Roughly 25% are "extremely confident" or "very confident" of their ability to afford prescription drugs without financial hardship in the next 10 years.

### *Worried about Medicare*

• Half of respondents who are not yet eligible for Medicare are "not too" or "not at all" confident that they will be able to afford health care without financial hardship once they are eligible for Medicare. A similar percentage are "not too" or "not at all" confident they will be able to afford prescription drugs without financial hardship under Medicare.

• Just 20% of Americans are "extremely confident" or "very confident" that they will be able to get the treatments they need once they are eligible for Medicare.

• Thirty-nine percent of those who received health care in the past two years say they are "not too" or "not at all" satisfied with health insurance costs, up slightly from 33% of respondents in 1998.

• Nearly 50% of respondents covered by employment-based health insurance are "extremely satisfied" or "very satisfied" with their current health insurance plan. Another 40% are "somewhat satisfied" with their plan, and 11% are "not satisfied" with their plan.

• One-quarter of respondents report that if their employer stopped offering health insurance they would not be likely to purchase coverage on their own.

Full-text printed copies of the executive summary are available for $25 prepaid, and pdfs are available for $7.50. To order, call (202)775-9132. ■

# Easy-access medications boost productivity

*Providing ibuprofen keeps workers on the job*

Looking for a simple way to help employers reduce lost work days? Suggest they invest in over-the-counter (OTC) medications.

A recent study by researchers at the University of Michigan in Ann Arbor found that 85% of hourly workers surveyed reported staying on the job when they had easy access in the workplace to OTC medications such as aspirin, acetaminophen, ibuprofen, cold/cough preparations, antacids, and skin ointments. Workers in the study reported that the medications reduced their symptoms enough that they could stay on the job and finish their shifts.

The study also found that workers frequently experience a variety of treatable symptoms while on the job. More than 73% reported that they regularly experienced headaches, colds, and sinus problems at work. Nearly 100% of study participants reported that access to medications helped them feel well enough to complete their shifts.

### *'Small investment with a large return'*

"We now have data that underscore just how valuable this is in keeping workers on the job and preserving productivity," notes study author **Yvonne Abdoo**, RN, PhD. "While this study involved a random sample of hourly workers at a manufacturing plant, it has implications for employers of all types. On-site health services, such as medications, appear to be a small investment with a large return."

"Every day I meet with employees suffering from colds, headaches, and similar ailments," adds **Debbie Woodruff**, RN, an occupational health nurse with Baxter Healthcare in Tampa, FL. "Although some people should go home, many with milder symptoms don't want to," she notes. "In these cases, I offer them various medications to provide relief, so they can be comfortable and do their jobs." ■

# Associations release diabetes guidelines

*AMA, JCAHO, NCQA coordinate measures*

Organizations representing the perspectives of physicians, health plans, hospitals, and other health care organization recently cooperated in the development of a common set of evidence-based measures for evaluating performance in health care. This first-ever collaboration may make collecting and reporting outcomes data much simpler for case managers working with disease management programs.

The release of the *Coordinated Performance Measurement for the Management of Adult Diabetes*, jointly prepared by the American Medical Association in Chicago, the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, and the National Committee for Quality Assurance in Washington, DC, lays the groundwork for testing a single-source approach to measuring performance of care provided to diabetes patients in multiple settings. It underscores the commitment of the three organizations to speak with a common private-sector voice on critical public-policy issues related to quality and performance measurement.

"By working from established clinical practice guidelines for diabetes care and by identifying the key data elements, this collaboration has produced a model for performance measurement that is firmly grounded in science and ready for implementation," stresses AMAExecutive Vice President **E. Ratcliffe Anderson Jr.**, MD. "The diabetes measures are the first in what we expect to be a series of collaborative measurement sets on clinically important topics."

The next phase is a demonstration project designed with the Maine Medical Assessment Foundation in Portland, a not-for-profit health services research and quality improvement organization. MMAF will use the diabetes measures in Maine as the basis for testing the feasibility of "single data collection," the collection of data for use in both physician- and health plan-level performance measurement from a single source such as physician offices.

"By working together," notes NCQA President **Margaret O'Kane**, "we are not only making performance measurement more efficient, but we are also bringing measurement down to the next level of the system where doctors and patients can relate to it and take advantage of it."

The collaborative partners' commitment to collecting information once, where possible, and using it to fill the multiple needs of the health care system hold the potential of reducing redundant, expensive data collection activities. This single-source approach ensures that physicians, provider organizations, and managed care plans receive consistent messages about the important aspects of diabetes care and in turn may improve the quality of that care.

"We believe that these collaborative initiatives have great potential to moderate the costs and data collection burden associated with performance measurement," says **Dennis O'Leary**, MD, president of JCAHO. "This approach also should make good sense to purchasers, consumers, and other users of performance data and information."

The AMA, the NCQA, and JCAHO plan to release measures for cardiovascular disease, pregnancy, and neonatal care within the next two years. A copy of the guidelines can be accessed on-line at www.ama-assn.org. ■

# 12-hour caregiver program helps families cope

*Course helps caregivers face uncertain future*

The diagnosis and treatment of a brain tumor often come with little preamble, leaving caregivers unprepared. And, because brain tumors strike at the very center of human thought, emotion, and movement, changes in cognition and personality, as well as symptoms of seizure and fatigue, can quickly overwhelm the patient's primary caregiver and stress the patient's support system.

For the past two years, the National Brain Tumor Foundation in Oakland, CA, has been fine-tuning a caregiver training course for the brain tumor community in the San Francisco Bay Area. It is designed to teach family caregivers practical home care skills and prepare them to become more active in the management of their loved ones' health care needs. With a major nursing shortage threatening to reduce still further the services case managers can provide patients and families in need, programs like the NBTF's

may help fill gaps in the health care delivery system. The NBTF now plans to extend the program's reach to other parts of the country.

"On a personal level, our goal is to reach family caregivers and encourage them to take the course before their need becomes critical," says **Sara E. Haynes**, BA, patient services program manager with the NBTF. "On an organization level, our goal is to demonstrate that home care, delivered by trained, nonprofessional caregivers, is an effective and low-cost alternative."

The course was funded by a three-year United Way grant. "We knew through our survey of our patient information line that 70% of all requests for information and support came from someone other than the patient — a family member or friend," says Haynes. "We also knew that most of the requests dealt with basic information and support — practical home care issues."

In addition to monitoring calls to its toll-free patient information line, the NBTF held several informal focus groups of eight to 10 current and past caregivers. "We found that caregivers were very ready to tell us what their information needs were," notes Haynes. "Unfortunately, their needs were all over the map."

The NBTF turned to Home Care Companions, a home health agency in San Francisco with an established training program for people caring for AIDS patients. "Home Care Companions had developed a successful curriculum for the AIDS population. We went to them to help us develop our training course. AIDS and brain tumor patients have some disease-specific care needs, but many issues affect all caregivers no matter what the diagnosis."

Using the data gathered from the patient information line and the focus groups as a guide, the NBTF developed a 12-hour course spread out over four-weeks. Education modules are presented by local health care professionals. "We offer an honorarium, but most of our presenters teach for free," says Haynes. "We have developed relationships with the local brain tumor community, and the professionals feel as committed to helping caregivers as we do."

## *The power of 'yes'*

The course is offered in the evenings, and dinner is included with the free education program. The course covers these eight topics:

• **Night 1/Part A: Overview of the medical aspects of brain tumor.** "We call this Neuroanatomy 101," Haynes says. "The class is presented by a neurosurgeon, oncologist, or neuroscience nurse. We also cover treatment options."

• **Night 1/Part B: Neuropsychological conditions and symptoms.** "We ask a neuropsychologist to present this part of the course," she notes. "This is a professional many family members don't know about. A neuropsychologist can be a wonderful resource to help families evaluate and manage personality and cognition changes in brain tumor patients."

• **Night 2/Part A: Symptom control and side effects of treatment.** The neuroscience nurse usually presents this education module, which helps prepare caregivers for the most common side effects of brain tumor treatment. "We provide caregivers with a list of tools to have in the home, such as medication to reduce fever," Haynes says.

• **Night 2/Part B:** This is the most popular module of the 12-hour course, Haynes notes. "We bring in a physical therapist to talk about the body mechanics necessary for basic home care skills, such as transfers. We always have at least one caregiver present with a back injury from trying to lift a patient improperly."

Course participants practice proper techniques on each other, explains Haynes. "For the rest of the evening, they practice lifting each other from chairs, lifting each other up from the floor, and transferring each other from a chair to the bed — it's really important to do these lifts and transfers properly, and few people have any idea how to perform those tasks without injuring themselves."

• **Night 3/Part A: Organizing a support network.** "This night is not just about asking everyone you know to help out," Haynes stresses. "We teach caregivers how to strategically ask the right people to help."

The NBTF trains caregivers to create a detailed schedule that includes every task that must be included in a day. "We ask them to keep that list close at hand, and when people ask, 'Can I help?' We tell them to answer with a firm, 'Yes!" That 'yes' should be followed with a very specific request."

In fact, the first thing caregivers see when they arrive for class on the third night is a large flip chart with the word "yes" written in large bold letters. "It's important that caregivers assess their needs before they become critical and learn to accept assistance," Haynes stresses. "Without assistance, caregivers are quickly overwhelmed."

The key to organizing a team of volunteer supporters is making requests specific and simple,

Haynes says. Examples that the NBTF provides caregivers include:

— If a neighbor goes to the store every Wednesday, ask if the neighbor can pick up a few items for you while they are out doing their own shopping.

— Ask one neighbor to come over and take the trash out to the curb the night before trash pickup.

"We urge caregivers to chart out an entire week and assign jobs," she says. "However, it's very important that these requests come from the caregiver and not the patient. "It's not fair for the patient to make a request. It's very difficult for anyone to turn down a family member or friend faced with a life-threatening illness."

• **Night 3/Part B: Accessing community resources.** A social worker delivers this part of the curriculum. "We discuss the need for respite care — not only to prevent caregiver burnout, but also to help the caregiver identify and assess changes in the patient for the physician," says Haynes. "It's impossible to notice subtle changes in cognition, function, or weight gain or loss if you are constantly by the patient's side. You have to go away and see if you notice any physical changes when you return."

Haynes says that many caregivers in the focus groups mentioned that they learned about available community resources too late to take advantage of them. "Few people are aware of the many programs available in their community," she notes.

• **Night 4/Part A: Legal issues.** An attorney leads this section, which covers wills, advance directives, and power of attorney. "We present this segment not from the standpoint that the patient must, for obvious reasons, have a will, advance directives, etc. We stress that the caregiver must also have these legal documents in order," she notes. "What if something unanticipated were to happen to the caregiver? Who would take care of the patient? There must be a contingency plan — a caregiving hierarchy — that spells out who will assume the caregiver role should the primary caregiver not be available."

• **Night 4/Part B: Funeral planning.** This is the education module that shocks most people, Haynes admits. "We ask a funeral director to come in and discuss the decisions families must make when faced with death. However, more than that, we are brokering an introduction to yet another professional that people ultimately will have to deal with. This is consumer awareness of funeral planning."

The course is not meant to be a support group, but for many of the roughly 100 individuals who have completed the course, informal support networks develop as a natural extension of the bonds established during the program.

"During breaks, we would gather and share information and ask each other questions," notes **Mike Meherin**, a resident of San Jose, CA, whose wife has been diagnosed with a brain tumor. "That exchange of ideas and information was very beneficial. I still keep up an e-mail correspondence with people I met in class."

Caregivers leave the program with a resource binder that contains all of the information covered in the class. "I know the information is there when I need it. The class gave me an awareness of what was coming down the line. As situations arise, I know I can pull out that binder and find what I need," Meherin says.

Unfortunately, brain tumor patients often deteriorate so quickly that caregivers don't have the time they need to absorb and implement the skills learned in class. **Stan Tsu** of Cupertino, CA, attended the course, but his wife's needs quickly outdistanced the training.

"As I learned new skills, I had to apply them immediately," recalls Tsu. "My wife went from diagnosis to death in a very short period of time. The NBTF training was right on the mark. It always seemed like as I learned something, I had to use it right away, or at times, I learned things I really needed to know the week before."

The NBTF currently receives referrals from its own patient information line, local hospitals, clinics, physician groups, and service agencies. "We've actively been working to improve our recruitment. We realize that we need to get to caregivers as early as possible following diagnosis. Recruitment is always a problem for caregiver training programs," Haynes notes.

To measure the effectiveness of its program, the NBTF administers a pre- and post-class questionnaire that includes an opportunity for open comments. "We test caregivers' knowledge of basic course content, such as three things to do for someone who is having a seizure. We also ask caregivers to tell us about their own perception of overall improvement," Haynes says. "What we hear most often is that caregivers are now able to approach issues they were reluctant to talk about with the patient prior to the course — tough issues, such as dying. They also tell us they have much greater empathy and understanding of the changes the patient is experiencing."

The NBTF is coming to the end of its three-year United Way grant, but not before launching a pilot program in Los Angeles later this year. "We want to continue to provide the program free of charge," explains Haynes. "The Los Angeles program will help us understand what our real costs are and what it will take to present the program throughout the country."

For more information, contact the NBTF patient services line at (800) 934-2873, or visit the organization web site at www.braintumor.org. ■


## Depression causes medical costs to soar

A new study sharply highlights the need for adequate behavioral health benefits. Patients with treatment-resistant depression cost the health care system thousands each year for both depression-related and general medical costs, according to the study presented at the recent American Psychiatric Association meeting in New Orleans.

Researchers analyzed medical and prescription claims data from the 1995-1998 MEDSTAT MarketScan Database to evaluate health care use and costs of patients with treatment-resistant depression.

Patients with treatment-resistant depression were categorized into two groups: low-to-moderate treatment resistance and severe treatment resistance. Patients in the first group had been treated with at least three antidepressants. Patients in the severe group had been treated with at least two antidepressants and hospitalized for depression. A comparison group of patients diagnosed with, and successfully treated for, depression without evidence of treatment resistance also was evaluated.

Researchers found that treatment-resistant depression is associated with higher inpatient, outpatient, and total health care costs. Specifically, the average total annual health care cost for patients with low-to-moderate treatment-resistant depression was $9,991 vs. $41,475 for those with severe treatment-resistant depression. Further, treatment-resistant patients were at least twice as likely to be hospitalized and had 15% more outpatient visits than non-treatment-resistant depression patients. ▼

## Novel drug surpasses SSRIs

A novel antidepressant that exhibits dual reuptake inhibition promises to surpass the popular selective serotonin reuptake inhibitors (SSRIs) for the treatment of major depression. Results of a study presented at the recent American Psychiatric Association meeting in New Orleans found that venlafaxine achieved significant remission of major depressive disorder after eight weeks of therapy.

Researchers analyzed data from more than 2,000 patients with moderate-to-severe major depressive disorder from eight randomized double-blind studies. Patients in these studies were randomized to receive venlafaxine, an SSRI, or placebo for eight weeks. Findings include:

- 43% of patients receiving a low dose of venlafaxine (75 mg) achieved significant remission at eight weeks.
- 45% of patients receiving a higher dose of venlafaxine (76 mg to 150 mg) achieved significant remission at eight weeks.
- 35% of patients receiving an SSRI achieved significant remission at eight weeks.
- 25% of patients receiving placebo experienced significant remission at eight weeks.

Venlafaxine works simultaneously on both serotonin and norepinephrine, two neurotransmitters implicated in depression and anxiety. ▼

## Drug prevents eating disorder relapse

Fluoxetine hydrochloride, a selective serotonin reuptake inhibitor used to treat depression, also helps people with anorexia nervosa maintain healthy body weight, according to a study released by researchers at the University of Pittsburgh (PA). The study is the first to suggest that an antidepressant may be useful in helping recovering anorexics sustain normal body weight after hospitalization.

Researchers followed 35 anorexia outpatients who had recovered a significant amount of their body weight for 12 months following hospital discharge. Fluoxetine was prescribed for 16 patients while the remainder took placebo. Among the patients on fluoxetine, 10 of 16 did not relapse and maintained a healthy body weight. Only three of the 19 patients on placebo were successful in maintaining a healthy body weight.

"Until now," notes lead investigator **Walter H. Kaye**, MD, professor of psychiatry at the University of Pittsburgh School of Medicine, "there have been no effective drug treatments for anorexia."

However, Kaye cautions that for fluoxetine to be effective, patients must first reach a healthy body weight. "If they are malnourished," he explains, "their serotonin system may be unresponsive to medication. Serotonin comes from tryptophan, an amino acid which can only be obtained in the diet," he notes. "Often, the only way to help patients return to a healthy body weight is through structured inpatient treatment. Once patients have a healthy body weight, medication that helps them maintain it outside the hospital and prevent relapse may ultimately save lives." ▼

## Antipsychotic provides long-lasting relief

A long-lasting, injectable formulation of the antipsychotic risperidone provides consistent, reliable symptom relief for schizophrenia and eliminates the need to take daily medication, according to a study presented at a recent psychiatric research meeting in Whistler, British Columbia, Canada.

"When taken as directed, many oral medications used to treat patients with schizophrenia work well," notes **John Kane**, MD, professor of psychiatry, neurology, and neuroscience at Albert Einstein College of Medicine in New York City. "However, a number of studies that followed patients with schizophrenia for three months to two years show that more than 40% of the individuals are unable to take their medication as prescribed — frequently leading to a return to their symptoms and renewed suffering. One significant factor is the difficulty patients have in complying with a regimen that requires pills to be taken once a day or more over an extended period of time."

This formulation, which has yet to be approved by the U.S. Food and Drug Administration in Rockville, MD, encapsulates risperidone in tiny microspheres made of a biodegradable polymer. The microspheres are injected into the muscle, where they gradually degrade to provide consistent blood levels of the drug.

In a three-month, randomized, double-blind, placebo-controlled study of 400 patients with schizophrenia, all patients were given oral risperidone in gradually increasing doses to a maximum of 4 mg per day over a one-week period. Treatment with oral risperidone continued for another three weeks after the injections began, to provide a smooth transition between formulations.

Participants were divided into four groups:

- 25 mg risperidone microsphere group;
- 50 mg risperidone microsphere group;
- 75 mg risperidone group;
- placebo group.

Patients in all groups received an injection every two weeks. All patients were monitored for signs of relapse. At the first sign of deterioration, patients were taken out of the study and treated. In all, 30% of patients in the placebo group withdrew due to insufficient treatment response compared to 22% for the 25 mg risperidone group, 16% for the 50 mg risperidone group, and 14% for the 75 mg risperidone group.

Patients in all three risperidone microsphere groups experienced greater symptom relief than patients in the placebo group. ▼

## Drug helps heart patients survive longer

Researchers at St. Michael's Hospital at the University of Toronto recently completed the first trial to compare the effectiveness of the two most common drugs for treatment of cardiac arrest. Results indicate that amiodarone outperforms the more commonly used lidocaine, say the study's authors. And that has major implications for the recommended standard of treatment for cardiac arrest by paramedics and hospitals across the United States and Canada, they note.

More than 250,000 Americans suffer out-of-hospital cardiac arrest each year, according to the American Heart Association in Dallas. Fewer than 10% of these cases survive. The vast

majority of cardiac arrests are caused by ventricular fibrillation (VF). Patients with VF die within five to seven minutes unless they receive cardiopulmonary resuscitation (CPR) and an electrical shock, or defibrillation, as early as possible. If defibrillation does not work immediately, the next step is administration of an antiarrhythmic drug, followed by additional defibrillations.

## Better than lidocaine

Prior to the Canadian study, the most commonly used anti-arrhythmic drugs had never been compared to determine which is most effective. Traditionally, lidocaine has been the drug used for cardiac arrest. However, last year, the American Heart Association Advanced Life Support guidelines recommended a promising drug called amiodarone as an alternative to lidocaine.

The Canadian study, ALIVE (Amiodarone vs. Lidocaine In Pre-hospital Ventricular fibrillation Evaluation), followed 348 randomized patients who had suffered cardiac arrest and who had one of the two drugs administered in a blinded fashion by Toronto Emergency Medical System paramedics. The study found that 50% more patients treated with amiodarone survived to be admitted to the hospital than patients treated with lidocaine.

"Although there have been major advancements in treating out-of-hospital cardiac arrest," notes **Paul Dorian**, MD, staff cardiologist and director of the Arrhythmia Service at St. Michael's Hospital and professor at the University of Toronto, "the overall survival rate has been relatively low. We knew we might be able to improve those odds by determining the




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### Editorial Questions

Questions or comments? Call **Russ Underwood** at (404) 262-5521.

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most-effective possible drug option. The results from ALIVE mean that we can now tell ambulance personnel and emergency room departments that amiodarone appears to be the most-effective drug, based on the evidence we have to date."

The ALIVE trial paves the way for further investigations to determine the longer-term survival of cardiac arrest patients, say the study's authors. This study followed patients up to the point of hospital admission, but a much larger trial is needed to verify whether more patients receiving amiodarone go on to survive to discharge from the hospital, they note. ■

## CE questions

For your convenience, *CMA* will be printing CE questions in each issue, beginning this month. Subscribers will receive a complete test and Scantron sheet in December 2001.

1. Which of the following is not an effective strategy for managing a telephonic case management interaction?
   A. set the ground rules
   B. schedule the televisit
   C. frame open-ended questions
   D. set up a documentation system

2. Which of the following is an effective strategy for bringing your health care agenda to the attention of the media?
   A. develop a relationship with local media
   B. identify hot topics
   C always follow up
   D. all of the above

3. Which of the following class of drugs was recently found to be effective in preventing relapse in patients with eating disorders?
   A. antidepressants, specifically SSRIs
   B. antihypertensives
   C. antipsychotics
   D. none of the above

4. Which of the following drug did Canadian researchers find was most effective in prolonging survival time for patients who suffer heart attacks outside the hospital?
   A. lidocaine
   B. amiodarone
   C. risperidone
   D. fluoxetine hydrochloride ■



## 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. ■

# Reports From the Field™

## Oncology

## Rapid test detects rare tumor cells

A rapid genetic test to help physicians evaluate lymph node biopsies for the spread of cancer at the time of surgery was introduced for the first time at the recent meeting of the American Association for Thoracic Surgeons in San Diego. The new test may help cancer patients receive more appropriate treatment, reducing the need to return for additional surgery by detecting the presence of rare tumor cells often missed by conventional microscopic evaluation.

**Tony Godfrey**, PhD, and **James Luketich**, MD, both associate professors of surgery at the University of Pittsburgh (PA), developed the genetic test that uses a commercially available instrument designed for rapid gene detection. Using a variation of the polymerase chain reaction (PCR) method of gene detection, Godfrey was able to detect, in less than 30 minutes, the cancer-related gene CEA in lymph node biopsies in cancer patients. The gene signals the presence of micrometastases, or difficult to detect tumor cells, indicating the spread of cancer.

"To properly treat cancer patients, lymph nodes need to be evaluated during surgery," notes Godfrey. "Unfortunately, current intraoperative methods are not sensitive enough to detect micrometastatic disease. As a result, many patients either are undertreated or undergo a second operation, once more sensitive and time-consuming tests identify disease spread. Our goal is to avoid these limitations by providing the surgeon with accurate and sensitive information at this pivotal point in the treatment decision process."

The new test appears to be more sensitive than conventional intraoperative methods that involve visual examination of the lymph nodes under a microscope, which often fails to detect cancer. In some cases, the new test surpassed even "gold standard" histopathology, which uses special tissue stains and preparations to detect microscopic traces of disease but takes anywhere from several hours to several days to provide results, Godfrey and Luketich note.

In a retrospective study, researchers examined lymph node biopsies from 30 esophageal cancer patients deemed cancer-free after surgical treatment. Researchers accurately identified which patients later experienced disease recurrence, indicating that this technique was able to identify early stage disease not detected by traditional histopathology.

In an ongoing prospective study, researchers have analyzed lymph node biopsies from 23 patients with and without cancer. The rapid test correctly identified two patients as positive that were deemed cancer-free during surgery and later deemed positive by final histopathology. The tests also accurately identified one patient as positive who was diagnosed as negative by both intraoperative ad final histopathology methods. This patient experienced disease recurrence several months after surgery.

The instrument used for the rapid gene tests performed in these studies, Smart Cycler, is manufactured by Cepheid in Sunnyvale, CA. ▼

## New method assesses breast cancer risk

A minimally invasive technique detected atypical cells in 23% of women at high risk of developing breast cancer, according to updated results of a large scale clinical trial presented at the recent American College of Obstetricians and Gynecologists (ACOG) meeting held in Chicago.

Ductal lavage is a method of collecting large numbers of cells from the breast milk ducts, where 95% of breast cancer originates. The procedure involves inserting a hair-thin catheter into the milk ducts and washing the ducts with saline to collect cells.

"Atypical cells significantly increase the risk of breast cancer development," explains **William C. Dooley**, MD, principal investigator with the University of Oklahoma College of Medicine in Oklahoma City. "This procedure is important news for high-risk women and their physicians who are searching for ways to understand their current risk of developing breast cancer."

The multi-center study enrolled 507 women who were at high risk for breast cancer on the Gail Index. ▼

### Kidney disease

## Blood pressure drug prevents kidney trouble

A low blood pressure medication, midodrine hydrochloride, also may help kidney disease patients avoid serious side effects of dialysis, according to studies presented at the recent annual meeting of the National Kidney Foundation held in Orlando.

Roughly 250,000 patients with end-stage renal disease undergo dialysis each year. However, after the toxins and excess fluids are removed, the vessels are unable to constrict and return blood to the heart, causing intradialytic hypotension (IDH), or very low blood pressure. The condition affects 20% to 50% of dialysis patients and may cause nausea, vomiting, dizziness, and even life-threatening symptoms such as abnormal heart rhythms and diminished blood supply to the heart and brain. These side effects most often occur in older patients, people with diabetes or heart disease, and people whose bodies cannot automatically compensate for dialysis-induced fluid loss. The side effects cause many patients to stop treatments.

"The complications of IDH take a substantial toll on patients' health and quality of life, which can force them to discontinue dialysis in the middle of their treatment," notes researcher **Mark Perazella**, MD, associate professor of medicine and director of the Acute Dialysis Services at Yale School of Medicine in Princeton, NJ. "This can increase the risk of infections and prolonged bleeding, and can even cause premature death. The data from these studies found that midodrine can reduce the symptoms associated with abnormally low blood pressure that can occur during dialysis."

In the two studies presented in Orlando and scheduled for publication in the *American Journal of Kidney Diseases*, Perazella found that midodrine was effective in patients with IDH who were resistant to other therapies. He also showed that the effects of midodrine were long-lasting. Patients showed significant improvement at one, five, and eight months of therapy. In a comparative study with cool dialysate, a proven therapy for dialysis-associated hypotension, Perazella found that midodrine was associated with fewer side effects, and there were no adverse effects observed. ▼

### Pain management

## IV drug reduces need for post-op narcotics

Administration of parecoxib sodium, the first investigational injectable COX-2 specific analgesic, significantly reduced the amount of morphine consumed by patients following total hip replacement surgery while improving overall pain relief, according to results from Phase III, placebo-controlled studies presented at the 20th Annual Scientific Meeting of the American Pain Society held recently in San Francisco.

The study included 175 patients. Patients were assigned randomly to receive a 40 mg dose of parecoxib sodium, a 20 mg dose of parecoxib

sodium, or placebo. Those patients receiving parecoxib sodium required 39% less morphine in the 24 hours following hip replacement than placebo-treated patients. Although the overall incidence of adverse events was similar in all groups, significantly fewer patients in the 40 mg parecoxib sodium group reported fever and/or vomiting than did those in the placebo group. These same 40 mg parecoxib sodium patients also scored significantly higher in Pain Intensity Difference scores at most or all assessment points, as well as in measures of overall well-being.

"Surgical pain management all too often requires a compromise between achieving maximum pain control and minimizing side effects," notes principal investigator **T. Phillip Malan**, MD, associate chair for research in the department for anesthesiology at the University of Arizona Health Science Center in Phoenix. "An agent that could both reduce the need for opioids and improve overall pain relief would be an exciting step toward better acute pain management."

In a second Phase III, multi-center, double-blind study presented at the same APS meeting, the control of pain following total knee replacement was evaluated in 208 patients using single IV doses of parecoxib sodium, morphine, or ketorolac, a traditional nonsteroidal, anti-inflammatory drug (NSAID).

Parecoxib sodium 40 mg provided analgesic efficacy comparable to ketorolac 30 mg and superior to morphine 4 mg at most point times. In addition, 80% of patients who received the 40 mg dose of parecoxib sodium rated their pain medication as good or excellent, compared to 70% of ketorolac patients and 45% of morphine patients. ▼

**Pediatrics**

## JCAHO: Healthy newborns at risk

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in Oakbrook Terrace, IL, issued an alert that a devastating but preventable condition can threaten healthy newborns.

The alert cautions hospitals that while jaundice is common and usually not life-threatening in newborns, severe cases of jaundice put babies at risk for kernicterus, or brain damage caused by dangerous levels of bilirubin in the bloodstream. Medical experts recently have seen a rise in this condition. Babies who survive suffer from a severe form of cerebral palsy, hearing loss, upward gaze paralysis, and teeth malformations.

JCAHO's *Sentinel Event Alert* newsletter warns that when high levels of lirubin go unrecognized, babies suffer the debilitating and potentially fatal consequences of kernicterus. The following factors put newborns at risk for hyperbilirubinemia:

- jaundice appearing in first 24 hours after birth;
- prematurity of three to five weeks;
- inadequate nutrition and hydration resulting from insufficient breast-feeding;
- bruising;
- ethnicity, in particular Asian-American and African-American babies, and babies of Mediterranean descent;
- siblings who experienced jaundice.

To protect newborns, JCAHO recommends that hospitals follow guidelines recently issued by the American Academy of Pediatrics in Elm Grove Village, IL, for identifying at-risk newborns, diagnosing kernicterus and treating the condition. Those include:

- Evaluate all cases of jaundice appearing in the first 24 hours.
- Create detailed treatment strategies for specific levels of bilirubin.
- Provide medical follow-up for newborns within 24 to 48 hours after discharge.
- Educate parents about jaundice and its potential risk.
- Provide proper equipment to detect and treat the condition.

For more information, visit the JCAHO web site at www.jcaho.org. ■

## 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 Russ Underwood, Managing Editor, *Case Management Advisor*, P.O. Box 740056, Atlanta, GA 30374. Phone: (404) 262-5521. Fax: (404) 262-5447. E-mail: russ.Underwood@ahcpub.com.

Information on conferences and seminars should be received at least 12 weeks before the event to meet publication deadlines. ■

# Resource Bank™

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

## Site links patients to clinical trials

Two information services companies recently launched a new service designed to match patients to appropriate clinical trials spanning all disease areas.

CenterWatch in Boston and HealthExchange in Stamford, CT, developed www.centerwatch.com, which features information on more than 40,000 ongoing clinical trials across a wide range of disease areas, profiles of research centers, as well as listings of investigational drugs and their results in clinical trials. In addition, visitors may receive active assistance in finding a clinical trial that fits their needs. ▼

## Site helps seniors beat blues

The Late-Life Depression Evaluation and Treatment Center at the University of Pittsburgh (PA) Medical Center (UPMC) recently launched a web site that connects older adults to information about mental health problems and provides an avenue to find help.

The site, www.latelifedepression.org, offers detailed information on many common geriatric mental health problems, including depression, anxiety disorders, grief and insomnia. The site is maintained by a team from the Intervention Research Center for Late-Life Mood Disorders, a clinical research center directed by Charles F. Reynolds III, MD, professor of psychiatry and neuroscience at University of Pittsburgh School of Medicine.

In addition to information about late-life mood disorders, the site offers links to other mental health resources on the Internet, information on referrals, and opportunities to participate in research studies.

Geriatric mental health disorders such as depression are featured on individual pages within the site with descriptions, facts and myths, information on common treatments, and articles by staff psychiatrists. In addition to patient information, the site also provides health care professionals with information about the Late-Life Evaluation and Treatment Center and how to refer patients. ▼

## Quick mental exam made easier

Psychological Assessment Resources in Lutz, FL, recently released a new version of the popular Mini-Mental State Examination (MMSE) originally developed by Marshall F. Folstein, MD, Susan E. Folstein, MD, and Paul R. McHugh, MD. PAR's new version represents the current standard form of the examination based on the original concept now commonplace in the literature, with minor subsequent modification by the authors, and reference to population-based norms.

The MMSE is a quick, cost-effective measure of an individual's cognitive mental state. It can be used by a variety of health care professionals to screen for cognitive impairment, estimate the severity of cognitive impairment at a given point in time, follow the course of cognitive changes in an individual over time, and to document an individual's response to treatment.

PAR's new "all-in-one" test form includes a detachable sheet with stimuli for the MMSE's comprehension, reading, writing, and drawing tasks. The form also includes alternative item substitutions for administration in special circumstances. Each package of forms contains a pocket-size user's guide, which provides detailed instructions for administration and scoring for each MMSE task, as well as recommended cutoff scores for use in classifying the severity of cognitive impairment. The guide also provides population-based norms useful for comparing an individual's MMSE total score with the appropriate reference group, or for interpreting the scores of individuals who are illiterate, who have had less than nine years of schooling, or who are 80 years of age or older.

The MMSE is $35 for 50 administrations and the user's guide. To order, call (800) 331-8378. ■

# American Health Consultants
# Education and Training Fax-back Survey

We would like to learn more about training and education needs for you and your staff. Please circle the number corresponding to your level of interest in the following topics:

| | No Interest | | Some Interest | | Much Interest |
|---|---|---|---|---|---|
| HIPAA privacy rules | 1 | 2 | 3 | 4 | 5 |
| Stark II | 1 | 2 | 3 | 4 | 5 |
| EMTALA | 1 | 2 | 3 | 4 | 5 |
| Aftermath of ergonomics | 1 | 2 | 3 | 4 | 5 |
| OSHA compliance | 1 | 2 | 3 | 4 | 5 |
| Post-exposure prophylaxis | 1 | 2 | 3 | 4 | 5 |
| Influenza update | 1 | 2 | 3 | 4 | 5 |
| Antibiotic resistance | 1 | 2 | 3 | 4 | 5 |
| Adverse drug reactions | 1 | 2 | 3 | 4 | 5 |
| Drug interactions | 1 | 2 | 3 | 4 | 5 |
| Medication errors | 1 | 2 | 3 | 4 | 5 |
| Herb-drug interactions | 1 | 2 | 3 | 4 | 5 |
| Nosocomial infections | 1 | 2 | 3 | 4 | 5 |
| Patient falls | 1 | 2 | 3 | 4 | 5 |
| Basic information for frontline workers | 1 | 2 | 3 | 4 | 5 |
| Needlesticks | 1 | 2 | 3 | 4 | 5 |
| Latex sensitivity | 1 | 2 | 3 | 4 | 5 |
| TB compliance | 1 | 2 | 3 | 4 | 5 |
| Restraints and the violent patient | 1 | 2 | 3 | 4 | 5 |
| Pain management | 1 | 2 | 3 | 4 | 5 |

| | No Interest | | Some Interest | | Much Interest |
|---|---|---|---|---|---|
| Palliative care | 1 | 2 | 3 | 4 | 5 |
| End-of-life care | 1 | 2 | 3 | 4 | 5 |
| Assisted suicide | 1 | 2 | 3 | 4 | 5 |
| Genetic testing | 1 | 2 | 3 | 4 | 5 |
| Organizational ethics | 1 | 2 | 3 | 4 | 5 |
| Human research protection | 1 | 2 | 3 | 4 | 5 |
| Informed consent documentation | 1 | 2 | 3 | 4 | 5 |
| New accreditation standards | 1 | 2 | 3 | 4 | 5 |
| Observation units (23-hour care or recovery beds) | 1 | 2 | 3 | 4 | 5 |
| ED diversion | 1 | 2 | 3 | 4 | 5 |
| Avoiding lawsuits: What to say when something goes wrong | 1 | 2 | 3 | 4 | 5 |
| Improving documentation for nurses and physicians | 1 | 2 | 3 | 4 | 5 |
| Nursing shortage | 1 | 2 | 3 | 4 | 5 |
| Bioterrorism | 1 | 2 | 3 | 4 | 5 |
| Disaster planning and mass casualties | 1 | 2 | 3 | 4 | 5 |
| Safety and security | 1 | 2 | 3 | 4 | 5 |

What training format is preferred for you and your staff? Rate the following methods using the scale below:

| | Least Preferred | | | | Most Preferred |
|---|---|---|---|---|---|
| On-site speakers | 1 | 2 | 3 | 4 | 5 |
| Travel off-site to live conferences | 1 | 2 | 3 | 4 | 5 |
| Subscription-based newsletters/journals | 1 | 2 | 3 | 4 | 5 |
| Outside-sponsored teleconferences | 1 | 2 | 3 | 4 | 5 |
| Outside-sponsored videoconferences | 1 | 2 | 3 | 4 | 5 |
| Web-based conferences | 1 | 2 | 3 | 4 | 5 |
| Resource books | 1 | 2 | 3 | 4 | 5 |
| Other _____ | 1 | 2 | 3 | 4 | 5 |

What is your title?_____

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