

Case Management

ADVISOR™

Covering Case Management Across The Entire Care Continuum

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American Health Consultants[®] is
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Professional development

Will the new Medicare regulations affect your chronically ill patients?

Before you say 'no,' read on — the rules have changed drastically

Who will take care of your chronically ill patients if changes in government regulations leave home health agencies and nursing homes no choice but to “just say no”?

If, as in the past, it still holds true that where Medicare goes other payers follow, case managers should be paying close attention to recent Medicare changes and the impact of those changes on the home health industry and other sectors of the health care delivery system. If you are a provider-based case manager, you probably already have felt the impact of reimbursement changes mandated by the Balanced Budget Act (BBA) of 1997. For those of you practicing outside the provider setting, a word of caution: Don't be too smug. The impact of the BBA and the reimbursement system known as the prospective payment system (PPS) may yet trickle down to your patients.

Since the beginning of the year, more than 1,100 home care agencies, mostly proprietary for-profit providers, have either closed or withdrawn from the Medicare program. National home care trade associations, such as the National Association of Home Care (NAHC), blame the Health Care Financing Administration's (HCFA, Baltimore) Interim Payment System (IPS), the precursor of the PPS. The IPS has wreaked financial havoc on the industry, NAHC says.

However, the home health industry has not taken this assault lying down. Home care agencies and associations nationwide have filed lawsuits against the U.S. Department of Health and Human Services, challenging the constitutionality and application of IPS. **(For more on pending legal actions, see story, p. 184.)**

In addition, home care associations recently stormed Capitol Hill demanding that Congress reconsider Medicare reimbursement changes. Gathering in Washington, DC, in September, the country's

leading home care groups joined forces in an effort to convince Congress to impose a moratorium on the Medicare home health IPS. The two-day rally was organized by NAHC (Washington, DC), the American Federation of Home Health Agencies (AFHHA, Silver Spring, MD), and the Home Care Association of America (HCAA, Washington, DC).

NAHC used the event to unroll a two-mile-long petition on the west lawn of the Capitol. The petition was signed by more than 10,000 home care providers, patients, state and national aging organizations, disability groups, churches, and state officials who support IPS reform.

“Without home health services,” said NAHC president **Val J. Halamandaris**, “thousands of people will be forced to prematurely enter nursing homes at a higher cost to their families and state Medicaid programs.”

Certain states have been particularly hard hit, argues NAHC. According to an ongoing survey of state home care associations that have been monitoring closures throughout the year, 64 home health agencies have closed in California, while 165 have closed in Louisiana, and 450 have closed in Texas.

Agencies proceed with caution

“Already home health agencies are much more cautious about which patients they will admit,” says **Sara Speights**, director of government affairs for the Texas Association for Home Care in Austin. “You are still eligible for home care; the problem is Congress isn’t going to pay for it. The agency is left hanging out there. They won’t take patients who aren’t going to get well and independent in a reasonable time and stay under that cap congress has set,” she explains. “Agencies are now in a position where it is all or nothing. They can’t legally abandon a patient. They can’t go in and give just *some* care. That means they won’t take that quadriplegic or brittle diabetic patient at all.”

Case managers have a responsibility to understand the new eligibility requirements and be prudent about how they document the status of

their patients, notes **B.K. Kizziar**, RNC, CCM, CLCP, case management consultant with Blue Cross/Blue Shield of Texas in Richardson.

“We also have to work with physicians to make sure they understand the criteria for home health. If we have a patient we know doesn’t meet criteria, it’s a disservice to the patient to move him from one home health agency to another looking for an agency creative enough to get Medicare reimbursement,” Kizziar says.

But home care agencies aren’t the only ones who are becoming more selective about which patients they admit. “Sick and complex patients are finding fewer options. No one wants to take them,” says **Sandra L. Lowery**, BSN, CRRN, CCM, president of Consultants in Case Management Interventions in Franscestown, NH, and vice president of the Case Management Society of America in Little Rock, AR. “There are many issues. The first is that so many providers — from the home health agencies to the acute facilities to the skilled nursing homes — have staffed down. Many providers simply can’t supply the necessary staff to care for a C-3 quadriplegic or other complex patient.”

A second issue is that providers are aware of the new PPS caps. The caps, which went into effect Oct. 1, represent a 15% reduction in home health payments as a result of freezing home health agency per-visit cost limits at 1993-94 levels.

“They know what their costs would be for a particular complex patient, and PPS won’t cover it. That means, the patient won’t be admitted,” says Lowery, adding, “Even patients with commercial coverage aren’t covered for chronic care in most cases.”

Jackie Soroko, RN, nurse case manager at Greenbriar Terrace Healthcare in Nashua, NH, agrees that the new Medicare rules are making life more difficult for the chronically ill. “We are very concerned about patient advocacy. But it’s certainly more difficult to provide care for any patient with chronic illness. PPS has moved facilities from a system that paid separately for ancillary services to one that pays a flat daily rate with

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no provision for outliers," she explains. "We're negotiating with ambulance services and labs to get better rates. It's what all facilities will have to do to manage the dollars Medicare now pays."

For some patients, there is no option but to shift costs to the states. "What you will see happening in the near future is a dramatic shift to the states," says Speights. "When these patients can't or won't be cared for with home health or nursing home placement, they will spend down all their money and become Medicaid eligible. What Congress and the tax payers have to understand is that just because you cut folks off, they don't just go away. The whole health care system is like a big mobile. If you push this end, everything else shakes." ■

Turning tides: Inpatient stays may lengthen

Transfer rule changes reimbursement

Last month was the deadline set by the Balanced Budget Act (BBA) of 1997 to implement changes in the ways some hospital discharges are viewed. Depending on whether a patient falls into the category of one of 10 predetermined DRGs, what were once considered discharges will now be labeled transfers, and Medicare reimbursements will change accordingly. (For list of 10 predetermined DRGs, see box at right.)

Hospitals no longer will be reimbursed on a per-patient basis. Instead, Medicare will compensate hospitals on a per-diem basis, offering twice the going rate for the patient's first day of hospital stay since that is where the lion's share of costs are. Whereas until now, because hospitals were allowed to keep whatever portion of the Medicare reimbursement that didn't go toward patient care, they had a strong incentive to discharge patients to post-hospital care facilities, including home health agencies, as quickly as possible.

The Department of Health and Human Services' Office of the Inspector General (OIG) examined 120 hospitals and six DRGs, comparing average lengths of stays within each category. The results, which were released in August, show that hospitals owning home

health agencies reported average lengths of patient stays to be six days, a day less than those reported by hospitals not owning a home health agency. These results were found to be true regardless of whether the hospital referred a patient to its own agency or an independent one. Moreover, within the DRGs examined by the OIG, patients who qualified as DRG 148 (bowel procedures), DRG 209 (joint replacements), and DRG 88 (chronic obstructive pulmonary disease) experienced significantly shorter stays — four days in the case of bowel procedures and one day for either of the latter two.

Under the new rules, hospitals will have less incentive to push patients out sooner, and that might not be bad, says **Lorraine Waters**, BSN, C, MA, director of Southern Home Care in Jeffersonville, Indiana. In fact, it could give patients more time to recuperate and adjust, she says.

Under previous rules, says Waters, discharged patients couldn't be seen by a home health care provider until three days after leaving the hospital in order to maintain the discharge status. That situation, she says, often failed the patient. Now, a decision as to whether a patient will receive home health care must be made within three days of admission. ■

Who Will Qualify?

- DRG 14.** Specific Cerebrovascular Disorders, Except Transient Ischemic Attack.
- DRG 113.** Amputation for Circulatory System Disorders, Excluding Upper Limb and Toe.
- DRG 209.** Major Joint Limb Reattachment Procedures of Lower Extremity.
- DRG 210.** Hip and Femur Procedures, Except Major Joint, Age >17 with CC.
- DRG 211.** Hip and Femur Procedures, Except Major Joint, Age >17 without CC.
- DRG 236.** Fractures of Hip and Pelvis.
- DRG 263.** Skin Graft and/or Debridement for Skin Ulcer or Cellulitis with CC.
- DRG 264.** Skin Graft and/or Debridement for Skin Ulcer or Cellulitis without CC.
- DRG 429.** Organic Disturbances and Mental Retardation.
- DRG 483.** Tracheostomy, Except for Face, Mouth and Neck Diagnoses.

Source: Health Care Financing Administration, Baltimore.

Case managers must encourage compliance

Agencies won't keep noncompliant patients

This is to put you on notice that if your Medicare patients are noncompliant, they might be discharged from home care. Noncompliant patients may include those who are not following their special diets or their doctor's plan of care.

Noncompliant patients also may include those who claim to be homebound but are still able to attend church each week. (For additional information about how case managers can boost compliance, see *Case Management Advisor*, June 1998, pp. 93-100; 105.)

Home health agencies must often make difficult choices about these types of patients, says Michael Walker, administrator of Continuing Care Home Health Services in Harrisonburg, VA.

Physicians are notified

Clients often must make difficult decisions, Walker says. "The agency is left with the choice of trying to abide by Medicare's strict regulations or meeting the client's needs. What we see happening more and more is where someone may better be served in an outpatient facility; or when they need to be seen by a doctor, they stay at home and think home care will take care of them for as long as possible."

Continuing Care Home Health Services addresses this issue with a policy that includes notifying physicians when a non-compliance issue arises. Home care employees document all communication with the physician and with patients.

Then the agency contacts the patients and gives a reason and date when services will be terminated. This is followed up with a letter. The agency also may give patients information about other home care agencies or community resources that could help. ■

Courts may cure home care's ills

Home care patients demand their day in court

Case managers who take their patient advocacy role seriously will watch with interest the outcomes of lawsuits pending against the Health Care Financing Administration (HCFA) in Baltimore. *Case Management Advisor's* sister publication *Hospital Home Health* recently reviewed three lawsuits filed against HCFA on behalf of home care patients and interviewed the plaintiff's attorneys.

Here's a summary of the lawsuits:

□ *San Martin Home Health et al. v. United States of America; Department of Health and Human Services; the Health Care Financing Administration; and Palmetto Government Benefits Administrators, a division of South Carolina Blue Cross and Blue Shield, a South Carolina Corp.* Filed July 2, 1998.

Austin, TX, attorney Mark E. Price filed the lawsuit in U.S. District Court in Dallas on behalf of 25 home health agencies and more than 30 Medicare beneficiaries. The plaintiffs include one quadriplegic man who had been receiving regular home health services until the interim payment system (IPS) took effect, Price says.

After IPS was implemented, the agency that had been serving him folded, and the registered nurse who owned the agency continued to see him without pay, Price adds. "But she's going to have to move to get another job and earn an income, and he will be left without home health care."

IPS has severely affected home health agencies and Medicare beneficiaries in Texas, where many patients had been receiving daily and twice daily visits for chronic, long-term conditions, he says. Already, so many home care agencies have closed in Texas that he has affidavits from 12 physicians who say they can't find home health agencies to care for their acute high-cost patients. "One physician is sending his nurse out at his own expense to help a severe diabetic," he adds. The woman must receive insulin shots twice daily, and she has no family or caregivers to help her.

Price says he receives five to 10 calls a day from Medicare patients who have heard about his lawsuit. He is working to turn it into a class action lawsuit.

The problems he describes are not surprising because Texas has so many home health agencies, many of them new, says Bill Dombi, director of

the Center for Health Care Law for the National Association for Home Care (NAHC) in Washington, DC. "Texas is going to be very hard hit [by IPS] because it had the largest number of home health agencies in the country, over 2,000 Medicare-certified home health agencies," Dombi says. "Lots of these were start-up agencies, serving long-term, higher-cost patients who are not accommodated under IPS." He says it was fairly typical of new agencies to provide 700 visits a year to patients who could not inject their own insulin.

The Texas suit claims the government's severe cuts in funding Medicare home health services have put hundreds of thousands of high-risk acute beneficiaries at risk of death or institutionalization. It also challenges the validity of the implementation of IPS provisions and related regulations, quoting a congressional resolution of June 5, 1998, that said: "The Administration should ensure that the implementation of the interim payment system does not adversely affect the availability of home health services for Medicare beneficiaries."

13 bills on IPS, and counting

The suit also claims IPS is irrational: "While Congress's primary purpose in enacting this payment scheme was to lower the costs to Medicare of providing health care to the elderly, sick, and disabled, while ensuring that they continued receiving the same quality of care, the Interim Payment System through its implementation by HCFA will achieve the opposite result and defeat the intent of Congress," it reads. "Patients will be forced to migrate to institutional settings, at a higher overall cost."

So far, Congress has 13 bills addressing IPS, Dombi says. These range from minor tinkering with the IPS rate-setting formula to substantial changes. He says NAHC compares IPS to the Titanic. "Every time you talk about tinkering with IPS, you're rearranging deck chairs; you may be adding a few lifeboats to the Titanic instead of bringing it into port."

The Texas Association for Home Care (TAHC) in Austin was the first to lose an IPS lawsuit. The Austin-based home care association lost its case, *Greater Dallas Home Care et al. v. U.S.*, filed March 31, 1998, when federal Judge Barefoot Sanders issued a 30-page ruling in June that IPS was unconstitutional, says **Sara Speights**, director of government affairs for TAHC.

□ *National Association for Home Care v. Donna Shalala, Secretary, U.S. Department of Health and*

Human Services. Filed April 15, 1998.

NAHC's lawsuit was filed in the U.S. District Court for the District of Columbia on behalf of all members and Medicare participating home health agencies in the United States. The lawsuit challenges the implementation and application of changes to the Medicare home health services benefit as contained in the Balanced Budget Act of 1997. Specifically, NAHC attacks the HCFA's final rule issued on March 31, 1998, claiming, "This final rule represents an unreasonable, arbitrary and capricious implementation of statutory authority."

The suit says that as a result of the defendant's illegal rulemaking, nearly 58% of all home health agencies will incur costs greater than their reimbursement for serving Medicare patients. NAHC's suit asks the court for injunctive and declaratory relief to stop enforcement of the published rule and to require HCFA to revise it.

□ *Vicki O'Neal of Carborro, NC; Patricia Rote of Forest Hill, MD; Mary Helen Gunkler of Eden Prairie, MN; and the National Spinal Cord Injury Association of Silver Spring, MD, v. Donna Shalala, Secretary, U.S. Department of Health and Human Services.* Filed May 6, 1998.

This suit, filed on behalf of all disabled or elderly Medicare enrollees in need of home health care, challenges HCFA's interpretation of the "confined to home" requirement under Medicare's home health benefit. "HHS has implemented and enforced an arbitrary and capricious interpretation of the Medicare 'confined to home' requirement to categorically deny coverage to persons with severe disabilities," the suit states. "As a result, Medicare home health services patients are faced with irrational and unexplained coverage denial determinations which fail to take into account and consideration individual patient needs, the attending physician's opinion, and the spirit of community inclusion." The plaintiffs asked the court for judicial relief to prevent further administrative erosion of the home health benefit.

[Editor's note: NAHC is keeping a careful watch on Washington and the courts. For more information, contact: Center for Health Care Law, National Association for Home Care, 228 Seventh St. SE, Washington, DC 20003. Phone: (202) 547-5262. Fax: (202) 547-3540. Web site: www.nahc.org.

The time may be right for case managers to make their on march on Washington. Watch for suggestions on how to make your voice heard on Capitol Hill in a future issue of Case Management Advisor.] ■

Will your patients fall through the cracks?

Changes in Medicare, acquisitions impact many

Home care is an industry under siege. Not only have changes in the Medicare reimbursement system forced more than 1,000 agencies out of business nationwide, but those agencies that are left are being devoured by corporate giants.

“The changes are coming fast. The telephone book is no longer a useful tool for a case manager trying to locate an agency for a client,” notes **LuRae Ahrendt**, RN, CRRN, CCM, nurse consultant with Ahrendt Rehabilitation in Lawrenceville, GA. “I recently told a colleague that when I call an agency now, I listen very carefully to the name given when the phone is answered. It’s very likely to be different from the name you were familiar with six months ago.”

With acquisitions and buyouts in the home health industry come other changes for case managers, she notes. “When new companies come in, they provide different standards of care, different training, and the process of bringing new people on board is delayed,” says Ahrendt. “These can be positive changes, but learning new personnel policies and trying to get cases started can be cumbersome. Referring cases into the agency and getting services started in a timely manner becomes more difficult.”

Of course, the other big news in home health is the new Medicare prospective payment system (PPS). “Everyone in home health seems uneasy. They aren’t sure what’s coming next, and I really believe that the initial cut backs from the Health Care Financing Administration are only beginning,” she says.

Perhaps most troublesome are the patient populations no longer covered by community care benefits. “There were some provisions for basic homemaking and bathing care under the old system. “The total removal of those services has left many clients and families devastated. There will be an increasing number of individuals who fall through the cracks in the coverage system between what is affordable and Medicaid eligibility. And most of those individuals are our parents.”

Ahrendt and others urge case managers to encourage clients to invest in a long-term care policy with good home health benefits before they become chronically ill. “As case managers,

I think we have a responsibility to encourage our clients to purchase these policies in their younger years before they need them and while they can still pass the physical and qualify for lower rates,” says **B.K. Kizziar**, RNC, CCM, CLCP, case management consultant for Blue Cross/Blue Shield of Texas in Richardson. “Remember, private insurance and Medicare both require that a patient have a skilled nursing need before approving home health benefits. With long term care policies, it’s an activity of daily living requirement. If you need help with two or more activities of daily living, you qualify for home health benefits under a long-term care policy.” ■

Special report: Alzheimer’s disease

(Editor’s note: This month we present the second of our two part special report on Alzheimer’s disease. Last month, we explored managed care/community partnerships to develop programs that support patients and their families, tools for ethical decision-making, and tools for developing meaningful activities for dementia patients. This month, we focus on appropriate care for end-stage Alzheimer’s.)

Hospice eases strain of end-stage Alzheimer’s

Hospice offers financial and spiritual benefits

The needs of Alzheimer’s patients for care and symptom management — and the needs of their family caregivers for education and support — are immense. An estimated 4 million Americans are affected by the disease, with that number expected to more than double in the next four decades, according to the Alzheimer’s Association in Chicago. And for those patients and their families, hospice may bring financial, physical, and spiritual relief at the end of life.

Hospice’s role in addressing this national tragedy can be problematic because of the difficulty in identifying a clear terminal phase of six months or less to live — and the increasing insistence by government regulators that providers must meet this basic requirement of hospice coverage. In addition, some hospices have questioned what they can bring to the care of patients

who are no longer able to communicate.

However, published guidelines and new research can help case managers and hospice providers make reasonable six-month determinations for many Alzheimer's patients. The real question is whether hospices are willing to use the guidelines and fight for hospice access for these patients. **(For further discussion of six-month determinations, see p. 189.)**

Alzheimer's is a terminal disease. There is no way to cure or reverse the progression of its destruction of the brain, called dementia. The U.S. Food and Drug Administration has approved two drugs for treating it, tacrine and donepezil hydrochloride, but these only postpone the inevitable. Eventually, on average within eight years, Alzheimer's patients become bedbound, requiring full-time care and assistance with all activities of daily living. By that point, their family caregivers may be financially devastated, emotionally and physically exhausted, and at risk for serious health problems of their own.

CMs can advocate for end-stage patients

Different databases indicate that the proportion of hospice caseloads devoted to Alzheimer's patients is somewhere between 1% and 3% — although this figure does not reflect the greater number of patients with other terminal diagnoses who have dementia as a secondary or comorbid condition. "Alzheimer's societies and advocates have been very vocal about their desire to see appropriate patients in hospice. They see that hospice is of great benefit," says **Stephen Connor**, PhD, vice president for research and professional development with the National Hospice Organization in Arlington, VA. Hospices, by contrast, have been somewhat more reluctant partners, he observes.

Katie Maslow in the Alzheimer's Association's Washington, DC, office sees a change in attitude toward hospice's role over the past year, "from 'This isn't going to work' to 'Let's figure out a way to make it work.'" Two workshop sessions at this year's Alzheimer's national education conference in Indianapolis directly addressed hospice's role in Alzheimer's care. The challenge, Maslow says, lies in identifying best practices in end-of-life care and finding effective models of collaboration between hospice programs and local Alzheimer's Association chapters.

While many hospice providers view the challenge of identifying a terminal phase of six

months or less as the primary barrier to a greater role for hospice, others question what hospice can bring to the care of Alzheimer's patients — particularly those residing in nursing homes, where their basic care needs are likely to be met by nursing home staff. It's left to case managers to help families advocate for end-stage Alzheimer's patients who lack the mental capacity to consent to hospice care and generally even the ability to say when they are in pain.

"Families and physicians often don't realize the appropriateness of hospice for end-stage Alzheimer's," says **Patricia J. Whitney**, MA, MBA, director of hospice for St. Mary's Hospice in Spring Valley, IL. "These families have gone through so much for so many years. Often Alzheimer's patients become bedbound at the end. They can't eat. They become incontinent. Just when families have a need to keep their loved ones at home, their only alternative becomes a nursing home." **(For information on how hospice helps nursing home patients, see p. 189.)**

Hospice gives families the ability to keep their loved one at home and help ease them into a natural death, notes Whitney. "Under Medicare Part

Portrait of a Costly Killer

- Alzheimer's patients eventually require 24-hour care.
- Roughly seven of 10 people with Alzheimer's live at home. Nearly 75% of home care is provided by family and friends. The remainder of care is "paid" care costing an average of \$12,500 annually.
- Half of all nursing home residents have Alzheimer's or a related dementia. The average annual cost of a patient's care in a nursing home is \$42,000.
- The average lifetime cost of caring for an Alzheimer's patient is \$174,000.
- The annual cost of caring for the 4 million Americans currently living with Alzheimer's is estimated at \$100 billion.
- The federal government covers \$4.4 billion of that cost.
- The states cover \$4.1 billion of that cost.
- Much of the remaining costs are paid by patients and their families.

Source: Alzheimer's Association, Chicago.

A, we can pay 100% of medical needs related to terminal illness. We can provide respite care, nurse's aides, medical social work visits," she notes. "Hospice provides the emotional, spiritual, and psychosocial support for families. Hospice also provides 13 months of follow-up care to ease families through bereavement. This helps families make ethical decisions about end-of-life care and later deal with their grief issues."

Families need to know what's happening

The goals of treatment for these patients are frequently hazy, notes **Lee Paton**, RN, MS, a doctoral candidate in gerontological nursing at Oregon Health Sciences University, Portland, who has developed an eight-week program for the Portland Alzheimer's Association chapter, aimed at educating family caregivers about the physical manifestations of end-stage Alzheimer's disease.

Threshold issues for families center on decision making around IV antibiotics, tube feeding, and IV hydration. Families have a desperate need for information if they are to make appropriate decisions, but the information they need is more than just physiology, Paton explains.

"Families are often called into medical conferences where the focus is on the physician or nurse trying to change their minds about care. I find families usually have completely different questions," she says. "How do you find out what are the real gut-wrenching issues for them?"

Families also need someone to explain what's happening as the patient is actively dying, a responsibility for which hospice is uniquely qualified to help these patients become less agitated or have less pain, she adds. "You also have a population of caregivers who go on to have medical complications of their own and who could really use the support of hospice."

Paton's course looks at the physiology, psychology, and spirituality issues of end-stage Alzheimer's. The eight week program is centered around Physician Order for Life Sustaining Treatment (POLST) developed by the Oregon Health Sciences University Center for Ethics in Health Care. "I wanted to help families understand what kind of decisions they would be asked to make using this form. Families must understand that what they are being asked is to make decisions about the manner of their loved

one's death, which is particularly hard when loved ones have dementia because you can't get that individual's input," explains Paton. **(For additional information on POLST, see story, p. 190.)**

Ladislav Volicer, MD, PhD, clinical researcher in the Geriatric Research Education Clinical Center at E.N. Rogers VA Medical Center in Bedford, MA, has studied end-stage Alzheimer's disease patients extensively and determined that antibiotics for recurrent infections in end-stage Alzheimer's patients do not extend their survival but can increase their discomfort. However, psychiatric conditions such as depression may require pharmacological management, he says.

"The issue of IV antibiotics for end-stage Alzheimer's patients is similar to the issue of IV hydration. It's often more a matter of how the dementia patient will react to new people, new environments, the process of the IV," notes Paton. "Even if the IV is started at home with a home infusion nurse, many families say that the impact would be too strong."

Case managers must help families look at the natural need to die at a certain time, says Paton. "The fact that we may prolong life by a few weeks with the use of IV antibiotics doesn't mean it's the right choice in all circumstances."

Whitney agrees. "The hardest issue for families to deal with is the need to let go," she says. "In many cases the family has lost the social aspects of their own lives after years of caregiving. An elderly spouse may have no one else left, which makes letting go even harder."

A way to avoid guilt

Questions Paton recommends that case managers use to help families explore include:

- For whom are we prolonging this life?
- Are we implementing this intervention simply because it's possible?
- What are the consequences of the intervention?

"One of the biggest benefits of hospice is that we work with families on anticipatory grief," says Whitney.

"If we can do that successfully, we avoid much of the guilt families of Alzheimer's patients feel when their loved one dies. When we come to end-stage Alzheimer's, the physical needs of the patient are not as demanding as the emotional needs of the caregiver," she says. ■

Bringing hospice into the nursing home

Why your nursing home patients need hospice

When end-stage Alzheimer's patients become bedbound, families often have little choice but to place them in nursing homes. This places a tremendous financial burden on families, but even more devastating is the tremendous guilt nursing home placement brings. When that stage comes, hospice can be your patient's best friend.

"Most nursing homes are understaffed. They may have one social worker for 120 beds. When hospice comes into the nursing home, we do everything. We make it clear to nursing home staff that we realize this is your facility, but you have to realize this is our patient, and we will win," says **Patricia J. Whitney**, MA, MBA, director of hospice for St. Mary's Hospice in Spring Valley, IL.

Fighting government regulation

The battles are many. "We have one patient in a nursing home and the nursing home is not administering the patient's pain medication," notes Whitney. "Hospice pain management is not understood in nursing homes. It's preventive pain management. It's time-released. Most nursing homes won't administer pain medications unless the patient appears to be actively in pain. We fight to get our patients their pain medications before they suffer."

In one case, the nursing home staff was not getting Whitney's hospice patient out of bed because the nursing staff felt the patient was in too much pain to be moved. "We told them, you move the patient, and we'll take care of his pain. In fact, the patient was in pain because he hadn't been moved."

Hospice also supplies nursing home patients with equipment to make their last days more comfortable. "We provide extra home health aides. Our own nurse acts as the case manager, and we bring equipment, as needed," says Whitney. "We had one nursing home using electric beds. Many of our patients can't get out of that type of bed, so we bring in our own beds. We also bring in our own oxygen and meds."

"Our patients get a lot more care than the average nursing home patient. If we don't like what we see happening to our patient, we will call the

state Department of Health," says Whitney, adding that she's only had to threaten to call the health department twice.

Now, the biggest battle hospice faces is with the federal government. "The nursing home population is the largest population we take care of," she says. "We are dealing with Medicare cutting back on nursing home reimbursement and forcing them out of business. Medicare complains we are duplicating services provided by the nursing homes, but we do so much more," she says. **(For more on hospice for end-stage Alzheimer's, see p. 189. For more on the impact of new Medicare payment systems, see pp. 181-186.)** ■

How to determine eligibility in Alzheimer's

When patients can't walk, consider hospice

Defining a terminal prognosis of six months or less to live, as required for a hospice admission, is one of the biggest barriers to enlarging the role of hospice in Alzheimer's care. These patients have been declining gradually for many years, and there may not be an obvious transition point or dramatic changes in their condition that would signal the need to consider hospice care. **(For additional information on the role of hospice in end-stage Alzheimer's care, see story at left.)**

However, *Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases, Second Edition*, developed by the National Hospice Organization (NHO) in Arlington, VA, provide a good starting point in qualifying Alzheimer's patients for the Medicare hospice benefit. NHO's medical guidelines for determining a terminal prognosis in chronic Alzheimer's or multi-infarct (stroke) dementias — as opposed to acute, potentially reversible dementias — start with functional status and the use of tools such as the Reisberg Functional Assessment Staging. Other such scales include the Karnofsky Performance Status Scale and the Global Deterioration Scale. According to NHO guidelines, an appropriate Alzheimer's patient for hospice would show all of the following characteristics:

- inability to ambulate without assistance;
- inability to dress without assistance;

Alzheimer's Hospice Resources

- Local Alzheimer's Association chapters or the national office in Chicago are among the best informational resources for both family caregivers and health care professionals. Contact: AA, 919 N. Michigan Ave., Suite 1000, Chicago, IL 60611. Phone: (800) 272-3900. Web site: www.alz.org. The association has also published a guide for developing dementia programs, *The Key Elements of Dementia Care*. Call (312) 335-5796 for ordering information.
- The Alzheimer's Disease Education and Referral Center of the National Institute on Aging, P.O. Box 8250, Silver Spring, MD 20907. Phone: (800) 438-4380.
- Earlier this year, Springer Publishing released *Hospice Care for Patients with Advanced Progressive Dementia*, edited by Ladislav Volicer and Ann Hurley, 320 pages; \$48.95 hardcover. Contact: Springer Publishing, 536 Broadway, New York, NY 10012-3955. Phone: (212) 431-4370. Fax: (212) 941-7842.

- inability to bathe properly;
- urinary and fecal incontinence;
- inability to speak or communicate meaningfully (with more than six intelligible words).

The first of these is the most critical factor, according to the research, although a recent study suggests that loss of meaningful communication, is also a key indicator of end-stage status. Other critical factors include difficulty in swallowing food or refusal to eat, and the presence of comorbid medical complications such as aspiration pneumonia, upper urinary tract infection, septicemia, or decubitus ulcers. Taken as a whole, the criteria suggest that appropriate hospice candidates with Alzheimer's disease will have lost the ability to walk and talk, while co-morbid conditions are starting to appear.

Use of the NHO criteria need not be terribly difficult, says **Patricia J. Whitney**, MA, MBA, director of St. Margaret's Hospice in Spring Valley, IL. "But if these criteria are in place, why aren't people putting their loved one into hospice? They've been taking care of their loved one for years, struggling on their own. By the time they get to the end, unless someone comes in and says, 'Hey, here's something that could really help,' they don't know." ■

Form helps families plan for patient's demise

Patient/family wishes at a glance

In Oregon, physicians routinely use the Physician Order for Life Sustaining Treatment (POLST) form to summarize patient's advance directives. The two-page, bright pink form is part of the patient's record.

The POLST form contains the following seven sections:

• **Section A: Resuscitation.**

- Resuscitate.
- Do not resuscitate.

• **Section B: Medical Interventions.**

- Comfort measures only.
- Limited interventions.
- Advanced interventions.
- Full treatment/resuscitation.

• **Section C: Antibiotics.**

- No antibiotics except if needed for comfort.
- No invasive (IM/IV) antibiotics.
- Full treatment.

• **Section D: Artificially administered fluids and nutrition.**

- No feeding tubes/IV fluids.
- No long-term feeding tubes/ IV fluids.
- Full treatment.

• **Section E: Discussed with:**

- Patient/resident.
- Health care representative.
- Court-appointed guardian.
- Spouse.
- Other (specify).

• **Section F: Patient/resident preferences as a guide for the POLST form.**

• **Section G: Review of this POLST form.**

The Center for Ethics recommends that the form be reviewed periodically and modified to reflect any significant changes in the patient's health status, care setting, or expressed preferences. A POLST kit is available from the Center for Ethics. The form and POLST wallet cards are available at a minimal fee, as well.

[Editor's note: To receive a POLST kit, contact: Oregon Health Sciences University, Center for Ethics in Health Care, 3181 SW Sam Jackson Park Road, Mail code L101, Portland, OR 97201-3098. Phone: (503) 494-4466. Fax: (503) 494-1260. E-mail: tolles@ohsu.edu.] ■

Asthma programs bring costs down

Home care agency provides asthma education

A review of its 1995 claims data revealed that six of Blue Care Network of Southeast Michigan's 24 primary care groups had exceptionally high utilization among its pediatric asthma patients. The health maintenance organization (HMO), based in Southfield, MI, immediately pulled together representatives from every facet of the organization to develop an asthma management program that successfully reduced annual utilization costs an average of \$673 per program participant. **(For other program results, see box, below right.)**

"Our approach was to go after those high utilizers of service, the patients with obvious treatment failures. Asthma is a disease that responds well to treatment. Good management can make a difference in medical costs and quality of life," says **James J. Lewandowski, RN, MHSA**, manager of health promotion and disease management for the HMO.

Blue Care Network called in representatives from all departments to work on the program. "You really need all departments to get a disease management program up and running," says Lewandowski. "Our provider representatives and the relationships they have with our providers help us deliver our message. Our quality management department had the necessary expertise in the continuous quality improvement method to help us look at outcomes management."

Blue Care Network launched the "Asthmatter of Fact" program in the six primary care groups with the high utilization rate for pediatric asthma. "We sent post cards describing the program to the families of children who had experienced treatment failures," he says. "This was a targeted, personalized communication that said the health plan was aware the child has a significant asthma-related condition and inviting them to participate."

Many of the families, however, seemed not to understand what the health plan was offering and didn't express an interest in enrolling in the program, he notes. "Each time the child was

admitted to the hospital or emergency room we sent another letter to the family," he says. In addition, a Blue Care Network nurse called the family to offer information about the program soon after the child's inpatient admission or emergency room visit. "We know that in terms of changing patient behavior, our best chances come during the event and immediately after the event. If we approach them several weeks or months after an asthma episode, they have much less interest in a management program."

On the provider side, Blue Care Network developed a comprehensive patient profile for each child in the high-utilization group. The profile lists what medications the child was taking and how often the prescriptions had been filled in the past 12 months, as well as any admissions. "This is the first time these physicians had seen this type of administrative report for their patients," he says. "We made it clear in a letter that accompanies the reports that we would like them to recommend their patients participate in the program."

Physicians were reluctant to accept the information contained in the profiles, he says. "They wanted to know where our information was coming from. It's simple, 90% of our members have pharmacy coverage, so we can track their prescription history." In fact, one physician called him to inform him that the profile of his patient was wrong. "He said I prescribed this drug for my patient that doesn't appear on the patient's profile. I suggested he call the family and check to see if

Portrait of Success

- ❑ Hospital admissions for the 54 "Asthmatter of Fact" pilot participants were reduced from a total of 14 in 1995 to a total of three in 1996.
- ❑ Emergency room visits for the 54 pilot participants were reduced from 21 in 1995 to six in 1996.
- ❑ The average annual inpatient cost per pilot participant was \$720 in 1995 compared to \$178 in 1996.
- ❑ The average post-intervention inpatient cost savings per pilot participant was \$542.
- ❑ The average post-intervention emergency room cost savings per pilot participant was \$131.

Costs of treatment listed above are averaged over the 54 pilot participants and do not reflect actual medical costs per episode. *Source:* Blue Care Network of Southeast Michigan, Southfield.

Tools for Success

The Asthmatter of Fact Patient Handbook includes the following teaching modules:

- program overview
- what is asthma?
- asthma triggers
- asthma medications
- managing asthma episodes
- personalized asthma tool kit
 - living with asthma
- asthma support services

It also includes these sections:

- program overview
- asthma management principles
- challenge of asthma care in the '90s
 - asthma care guidelines
 - asthma treatment outcomes
- reference articles and materials
 - practice profile

Source: Blue Care Network of Southeast Michigan, Southfield.

the prescription had been filled. He later called me back and told me the family hadn't filled the prescription because the child improved." Physicians now receive patient profiles each quarter.

In addition to trying to change member behavior, Blue Care Network was interested in changing physician behavior. "In reviewing these profiles, I often didn't see the numbers of refills or types of prescriptions I would have expected," says Lewandowski.

Once a physician approves a patient's participation in the program, Blue Care Network sends the referral to a local home care agency. "We surveyed local providers and found those that met our specifications for what we considered asthma expertise. We worked with them to develop two asthma manuals: one for patients and one for providers."

Blue Care Network also had a nurse clinician train physician office staff how to deliver asthma education to their patients. "It's more often the office staff that educates the patient, not the physician. We felt including the staff in asthma education was an important step. Luckily, we received an educational grant from a pharmaceutical company to cover the costs of staff education."

A home care nurse goes to the patient's home to deliver the eight teaching modules in the patient manual. **(For a list of modules covered in both manuals, see box, above.)** The home care nurse makes an average of four visits to cover the information in the manual. "The nurse has made

up to eight visits for a family that is really having trouble," says Lewandowski. "The learning visits take place over no more than a four-week period and ideally are completed in two weeks."

In addition to asthma education, the home care nurse provides the following services:

- evaluates the home for environmental asthma triggers and discusses them with the family;
- observes the children using their inhalers and peak flow meters;
- helps the physician develop a personal asthma management plan for each child and then goes over that plan with the family;
- coordinates visits with an allergist.

Patients enrolled in the Asthmatter of Fact program receive quarterly phone calls from the home care nurse. "The nurse goes over compliance issues, asks about how the child's peak flows have been," Lewandowski says. "The nurse also checks for potential signs of trouble our claims data might not pick up, such as missed days from school due to asthma." ■

Workers' comp/disability management

Early intervention brings comp success

Nursing staff deliver, costs slashed

Intel in Santa Clara, CA, has an impressive workers' compensation record. Over the past four years, the injury rate at Intel has been reduced by an average of 33% each year from each previous year. In 1997 alone, Intel's injury rate dropped 39%, and its lost-day case rate fell 42% compared to 1996. With an impressive 0.74 recorded injuries per 100 employees, the semi-conductor giant credits its success with its emphasis on prevention and its aggressive medical case management.

Intel employs 120 occupational health nurses and 10 nurse case managers worldwide who move in quickly to manage the case when an employee is injured, says **Susan Adams**, RN, BA, COHN, senior corporate occupational health nurse for Intel based in Chandler, AZ. "Our basic philosophy is to provide 24-hour by seven-day coverage for all our manufacturing facilities. Our nurse case managers support the occupational health nurses

on-site under the supervision of the occupational health manager by taking over medical management of cases when they reach the reportable stage.” (See box at right for Intel’s formula for determining nurse-to-employee ratios.)

“We don’t want to leave cases to the workers’ comp administrator to handle,” adds **Joe Crunk**, corporate safety and security director for Intel based in Chandler, AZ. “You have to maintain personal contact between the employee and the company to be as successful as we’ve been. There are times when a physician makes a recommendation to the employee, and supervisors at the company are unaware of those recommendations. The case manager maintains close contact with the physician and keeps everyone well-informed about each case.”

Adams has no direct authority over the nurse case managers but does oversee their performance. “We have routine teleconferences and met twice a year for face-to-face meetings,” she says. “In teleconferences, we work on projects and review case studies. We bring certain challenging cases to our teleconferences so that the assigned case manager can receive input from every one.”

‘We believe that any injury is preventable’

Case management staff also play an important role in several companywide projects. “Right now, case managers are working with our legal team on Americans with Disabilities Act (ADA) compliance issues and medical leave of absence guidelines,” Adams says.

Aggressive medical management is not the only key to Intel’s success, Crunk says. “We believe that any injury is preventable. I don’t want people to get the impression that if you hire enough nurses, you can control your medical costs. Prevention is an essential part of our total program.” In addition to its nursing staff, Intel employs 20 ergonomists.

Intel begins preventing injuries long before new equipment is even introduced to its employees. “We spend a lot of time working with our suppliers and equipment manufacturers before equipment is brought into our manufacturing plants. We’re a pioneering company. Many times it’s the first time some of this equipment will be used by any organization. We want to look closely at that equipment and make sure it’s built as safely and ergonomically correct as we know how.”

Formula for Success

Intel employs 120 occupational health nurses worldwide using the following algorithm:

- one nurse for every 800 manufacturing employees.
 - one nurse for every 1,200 office employees.
- Some countries overseas dictate slightly different nurse-to-employee ratios.

Source: Blue Care Network of Southeast Michigan, Southfield.

In addition, Intel spends a lot of time on employee awareness and training programs on ergonomic issues. “We had a big effort starting in 1992 to train employees how to prevent injuries by getting help before serious problems arise,” says Crunk. “Employees are trained to report to the nurse the minute they notice a pain in their elbow or wrist after using certain equipment. The nurse looks at the equipment and observes the employee working and, often with the help of an ergonomist, makes suggestions for changing the setup or the task frequency. If necessary, the nurse refers the patient to physical therapy,” he says, adding that Intel provides in-house physical therapists in many of its organizations.

“None of us work in isolation. We work in teams with other disciplines on each case, as well as general safety concerns,” Adams says.

The emphasis on ergonomics also has yielded excellent results, she notes. Intel’s musculoskeletal disorder rate was 1.13 injuries per 200,000 man-hours worked in 1994 compared to 0.13 injuries per 200,000 man-hours worked, or a reduction of 88%.

In 1991, Intel benchmarked several companies it felt had excellent safety records and looked closely at how those companies were managing their safety programs. “We created our own safety model, and the prime contributor to our success is the safety self-assessment each major organization in Intel conducts annually.”

Intel organizations are asked to score themselves on a number of safety areas, including:

- management commitment;
- line management and accountability;
- safety support personnel, such as nurses and ergonomists;
- safety training;
- motivation and discipline, with an emphasis on individuals disciplining themselves to be more safety conscious;

- results, such as numbers and types of injuries.

Once an Intel organization completes its annual safety assessment, Crunk and an Intel vice president visit each organization to review the survey results. "We spend a full day at each organization. We take a tour of the facility. We talk to personnel and look closely at conditions. We even have lunch with a cross section of employees to get their feedback about current conditions and suggestions for future improvements," he explains.

Crunk presents a quarterly update of environmental health and safety programs to senior management. Also, he sends out a monthly electronic report on the status of each Intel organization's safety performance.

"We compare this year's performance to last year's and rank organizations to show how they're doing compared to other Intel organizations," he says. "Organizations that have successfully reduced their injuries get recognized. We've built a fair amount of pride in that recognition." ■

Managed care

Doctors in HMO embrace alternative therapies

Study: Patients, providers interested in therapies

A recent study conducted by Kaiser Permanente in Oakland, CA, found that nearly 90% of the health plan's primary care providers had provided or recommended alternative therapies to adult plan members in the previous 12 months, primarily for pain management.

Perhaps even more surprising were the reasons providers listed for recommending alternative therapies, says **Nancy Gordon**, ScD, research investigator with the division of research medical care program at Kaiser Permanente in Northern California and the study's lead author.

"When we asked clinicians which set of factors motivated their interest in alternative therapies, the leading motivator was a belief that patients could not be adequately treated by more conventional methods," she notes. "The second most common motivator clinicians listed was a belief that many health problems, such as menopause, osteoporosis, and premenstrual syndrome (PMS) could be treated more effectively using a holistic approach."

The study found the alternative therapies most commonly recommended or practiced by Kaiser providers include chiropractic, acupuncture, massage therapy, biofeedback, and relaxation techniques. Only 10% of providers used or recommended herbal or homeopathic medicine. However, of all providers, women's health providers expressed more interest in herbal medicine.

How They Did It

Researchers at Kaiser Permanente in Oakland, CA, conducted three surveys with questions relating to alternative therapy use.

- ❑ In the spring of 1996, the large health maintenance organization (HMO) mailed surveys to 3,000 health plan members and all primary care providers working in adult medicine, plus a random sample of women's health providers, including obstetricians/gynecologists and nurse practitioners.
- ❑ More than 750 providers, including 624 adult primary care physicians and 157 women's health providers responded to the provider survey.
- ❑ More than 1,500 adult health plan members responded to the member alternative therapy survey.
- ❑ Providers and adult plan members were asked to answer questions about their experience with 20 alternative therapies, including acupuncture, chiropractic, and herbal medicine.
- ❑ In addition, several questions about alternative therapies were added to the member health practices survey the HMO conducts every three years.
- ❑ Of the 34,000 adult members surveyed, 17,735 completed and returned surveys on health practices.
- ❑ Kaiser also conducted phone surveys with a random sample of non-responders to both the provider and member alternative therapy surveys to make sure findings were consistent with those on returned surveys. ■

More than 60% of adult care providers and roughly 75% of women's health providers said they wanted Kaiser to provide greater access to alternative therapies. Less than 15% of all providers surveyed said they absolutely did not want the HMO to offer greater access to alternative therapies.

Other study findings include the following:

- 31% of members had used at least one alternative therapy in the past 12 months.
- 50% of members had used an alternative therapy at least once in their lifetime.
- 93% of providers had used or recommended at least one alternative therapy listed on the survey in the past 12 months.

"When we took psychological counseling, special diets, 12-step programs, and prayer out of the mix, that fell to 89%," Gordon says. Similarly, when the same therapies were removed from the member list, the percentage of members who had used alternative therapies in the past 12 months fell from 31% to 25%. "If health plans are going to be serious about looking at what alternative therapies they're going to provide, they need to understand what their members are using, what their doctors are recommending for what types of problems, and where the two overlap."

"We take these findings very seriously," says **Harley Goldberg, DO**, regional coordinator of complementary and alternative medicine for The Permanente Medical Group, which delivers care to the 2.8 million Kaiser Permanente members in northern California. "We're working rapidly to make those therapies that are safe and effective available to our members."

Goldberg says Kaiser set up an advisory panel of clinicians and alternative therapy experts to use an evidence-based approach to evaluate the efficacy and safety of alternative therapies. "If there is no evidence to support the use of a particular therapy, we've agreed to go no further in providing that therapy," he notes. "In some ways, that creates a downside because I'm sure there are alternative therapies which are effective but for which no evidence yet exists."

The next issue the advisory panel must tackle is quality delivery, he notes. "How do you determine who is the qualified practitioner to deliver an alternative therapy? For acupuncture, you have physicians who practice acupuncture, and there are licensed acupuncturists. And which are the best delivery systems? Do you bring the service in-house?"

There also are issues of adverse effects and contraindications to consider, such as herb/drug interactions, he says. "Roughly 75% of patients who are using alternative therapies don't mention it to their primary care provider, even when the provider asks a direct questions. It's clear that providers get more information when they ask about alternative therapy use than they do when they don't ask. Part of our job is to educate our providers about alternative therapies and to encourage them to question their patients about alternative therapies. About 75 out of 100 patients will answer honestly, if their provider ask them direct questions about which alternative therapies they use."

[See also: Gordon N, Sobel DS, Tarazona EZ. Use of and interest in alternative therapies among adult primary care clinicians and adult members in a large health maintenance organization. *West J Med* 1998; 169:153-161.] ■

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CE objectives

After reading this issue of *Case Management Advisor*, continuing education participants will be able to:

1. Explain the new Medicare transfer rule.
2. List most important criteria for making a six-month determination for an end-stage Alzheimer's patient.
3. Describe components of a successful asthma management program.
4. Identify alternative therapies most often recommended by primary care providers in a health maintenance organization. ■