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Case Management ADVISOR™

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American Health Consultants® is A Medical Economics Company

Behavioral health/workers' comp/disability management

Employee wins groundbreaking claim for mental disability

Jury awards more than $225,000

A federal jury in New Jersey awarded more than $225,000 earlier this year to a man who was ridiculed at work because of his neurological impairments. The jury in the case, *Lanni v. NJDEP* (New Jersey Department of Environmental Protection), 96-3116 (AET), found violations of both the Americans with Disabilities Act (ADA) and New Jersey's Law Against Discrimination.

"Although the ADA does not specifically prohibit workplace harassment of the disabled, federal law does not explicitly ban sexual harassment, either. Courts, however, have readily decided that severe and pervasive sexual harassment is a form of sex discrimination. In a similar fashion, employers are likely to be held responsible for harassment directed at a worker because of a disability," says **K. Tia Burke**, JD, an employment law attorney with Christie, Parabue, Mortensen and Young in Philadelphia.

"An established pattern of harassment is likely to be actionable."

It's true that discrimination laws don't prevent harassment. "However, case law is central in the disability context, and this type of harassment certainly could be actionable if it meets the standard of severe and pervasive harassment," notes **Carol Miaskoff**, JD, assistant legal counsel for coordination in the Office of Legal Counsel for the Equal Employment Opportunity Commission in Washington, DC. "One incident is not enough. However, an established pattern of harassment is likely to be actionable."

Every case manager working in the mental disability arena should know this case law, says **Mark Raderstorf**, CCM, CRC, LP, LFMT, president of Behavioral Management in Minneapolis. "Case managers can bring cases like this to the attention of employers in order to educate

them about the importance of treating employees with mental disabilities in a fair and humane way."

Burke agrees, with one caveat: "Case managers must never share confidential employee information with supervisors or co-workers without the employee's permission," she says. "Written documentation is the best way to demonstrate you have an employee's permission to share personal information with others. It should be clear both whether you have permission to disseminate information and to whom you have permission to disseminate that information."

Lanni v. NJDEP

Phillip Lanni of Trenton, NJ, alleged that he was constantly ridiculed for his neurological impairments, which include dyslexia, during his five-year tenure as a radio dispatcher for the state Department of Environmental Protection's division of fish, game, and wildlife. Lanni claimed he was the target of jokes about his dyslexia and was ridiculed because of spelling errors, a common characteristic of his disability. On the job, Lanni also mixed up words, spoke slowly, winced his eyes when he spoke, and sometimes asked for words to be repeated.

He alleged supervisors called him "moron" and "stupid." When he complained of the harassment, Lanni claimed he was told to "get used to the locker room atmosphere." This led him to take a leave of absence from an environment he considered hostile. He filed claim in 1996. At that time, his supervisors were "appropriately disciplined with mandatory counseling for their behavior," according to a spokesperson for the New Jersey Attorney General's office. The jury found the state and two supervisors liable. It awarded Lanni $70,930 in back pay and $156,100 in non-economic damages. The jury did not award punitive damages.

"It's very difficult to explain to a judge and jury what it means to have neurological impairments. In addition to his learning disabilities, Lanni suffered from other neurological impairments, including an awkward gait, caused by an injury he suffered as a child and complications his mother experienced during her pregnancy," says Lanni's attorney, **Linda Wong**, JD, a partner with Wong, Tsai, & Fleming in Edison, NJ. "His co-workers stereotyped him as stupid and emotionally unstable, and that's where the problems started to come in."

"The standard for an actionable harassment case is 'severe and pervasive' behavior. There are no black and white rules here," notes Miaskoff. "However, analytically, the standard means that behavior is actionable as soon as it changes the terms or conditions of employment for an individual. In other words, when this individual comes to work, they have a job that has different terms and conditions than someone else in the workplace with the same job."

"People can relate to blindness," Wong says. "They can relate to someone being in a wheelchair. However, when it comes to neurological impairments, we have to begin the case by proving to the jury and judge that the mentally handicapped deserve protection under the law."

"This case demonstrates the value a case manager can bring to an employer or policy holder," says Raderstorf. "If appropriate steps had been taken to educate staff about the nature of Lanni's disabilities, the pattern of harassment may have ended before a claim was filed."

Help workers understand

Lanni did make personal attempts to educate his co-workers about his disability, notes Wong. "He placed articles about dyslexia in his co-workers mail boxes, but they were not taken seriously."

Raderstorf currently has a client with a mild to moderate brain injury. "He walks fine. He talks fine. However, he does have cognitive problems, and his co-workers are making fun of him," he says. "Case managers who have clients with hidden disabilities must help employers, supervisors, and co-workers understand that the employee is not lazy, insubordinate, or lacking in motivation. There is a false perception that individuals with

neurological impairments or psychiatric disabilities are 'normal' but just not willing to do their jobs."

The client's supervisor has sent memos reviewing the client's job performance in a very "condescending manner which could almost be considered harassing." Raderstorf has set up several meetings with his client's supervisor to help him find more appropriate ways to comment on the client's work performance.

"For the employee with cognitive impairments, learning disabilities, or other mental disorders, supervisor feedback must be done in an educational way. The supervisor is obviously frustrated by my client's job performance. I'm trying to help him find more appropriate ways to express his concerns," he says.

Provide sensitivity training

Raderstorf suggests supervisors share this advice with case managers:

- Tone down your feedback to employees with mental disabilities.
- Always use an instructional rather than an accusatory tone.
- Never demean the employee verbally or in written job performance evaluations.

Wong says case managers also should encourage employers to provide sensitivity training about mental and physical disabilities in the workplace. "Our office provides sensitivity training on sexual harassment. I think it's appropriate to talk about discrimination against disabilities, as well."

In addition, employers should have a clearly established complaint mechanism, she says. "Supervisors should understand the complaint mechanism and know the employer's discrimination policies. Unfortunately, in the Lanni case, supervisors participated in the discriminatory actions."

Raderstorf plans to bring an article about the Lanni case to his next meeting with his client's supervisor. "I hope it will help finally make it clear to him this is a potential problem."

[Editor's note: For other case law relating to discrimination against the mentally disabled, see Levinson v. Prentice Hall Inc., *88-5637 (3rd Circuit 1989) and* Lehman v. Toys 'R Us, *132 NJ 589 (1993). For more on the ADA and mental disability, see* Case Management Advisor, *February 1999, pp. 29-31.]* ■

Psych visits increased in 1998; depression cited

Psychiatric prescription costs rose, too

Psychiatrists received 58 million patient visits, the majority for the treatment of depression, during the 12 months ending October 1998, according to recently released data from pharmaceutical consulting firm Scott-Levin in Newtown, PA. That figure represents a 4% increase over the previous 12 months. The top five reasons for those visits, according to Scott-Levin's Physician Drug & Diagnosis Audit, were:

- single episode depression (15%);
- depressive disorder (12%);
- anxiety states (9%);
- neurotic depression (7%);
- recurring-episode depression (6%).

In addition, psychiatrists were responsible for $5.6 billion in retail prescription sales during the year ending October 1998, a 21% increase compared to the previous 12-month period, according to Scott-Levin's Source Prescription Audit. Psychiatrists wrote 93.1 million retail prescriptions, a 5% increase over the previous 12 months, for an average of 1,185 prescriptions per physician.

Advertising has effect

The top five therapeutic classes prescribed by psychiatrists were:

- specific neurotransmitter modulators, selective serotonin reuptake inhibitors (SSRIs), and selective norepinephrine reuptake inhibitors (SNRIs) (24.5%);
- seizure disorder therapies (10.4%);
- anti-psychotics (9.5%);
- benzodiazepines (9.3%);
- similar antidepressants (7.5%).

The Physician Drug & Diagnosis Audit indicates that physicians often use SSRIs and SNRIs, such as Prozac, Zoloft, Paxil, and Serzone, as replacements for tricylic and tetracyclic antidepressants. A Scott-Levin spokesperson notes that direct-to-consumer advertising of antidepressant drugs may at least partially explain the increases in both patient visits to psychiatrists and psychiatric retail prescription sales.

(Editor's note: For more information, visit the firm's Web site at www.scottlevin.com.) ■

CMs can help reduce misdiagnosis

How to differentiate states of consciousness

Recent studies indicate there is a high incidence of diagnostic inaccuracy in patients with disorders of consciousness. A new term, "the minimally conscious state," currently is gaining acceptance and promises to reduce the incidence of misdiagnosis. Understanding the differences between a vegetative state and a minimally conscious state gives payers and providers a valuable basis for evaluating treatment designs.

"The issue of potential misdiagnosis is very controversial," says **Joseph T. Giacino**, PhD, associate director of neuropsychology for the Center for Head Injuries at the JFK Johnson Rehabilitation Institute Center for Head Injuries in Edison, NJ.

"There are three studies which are widely cited," he explains. "The rate of misdiagnosis reported in those studies ranges from 15% to an alarming 43%. I think the thing to take away from these studies is that there is a degree of misdiagnosis. and it affects the effectiveness of treatment interventions." **(See box, p. 57, for studies on states of consciousness.)**

Finding consensus

Representatives from the fields of neurology and rehabilitation met last year in Aspen, CO, for the Aspen Neurobehavioral Conference Work- group and developed the "Assessment, Prognosis and Treatment of the Vegetative and Minimally Conscious States: The Aspen Neurobehavioral Conference Consensus Statement," says Giacino, who was a conference participant, adding that the paper recently was prepared for publication.

The consensus statement resolves many of the conflicts that surround the diagnosis of disorders of consciousness in an effort to reduce the high incidence of misdiagnosis in this group of patients, he explains.

The most important thing to emerge from the Aspen meetings, says Giacino, was the introduction and refinement of a new condition known as the minimally conscious state (MCS). "The MCS is a condition of severely altered consciousness characterized by definite, although inconsistent, evidence of conscious behavior," he explains. "The conscious behavior is not present all the time, but when it is, it's unmistakable. In a vegetative state, there is never evidence of conscious behavior."

Yes, but can you do that again?

There are four specific diagnostic criteria for conscious behavior. The presence of any one of the four is necessary for a diagnosis of MCS, Giacino says:

- **Simple command-following.** "This must be discernable and reproducible behavior. For example, the patient's index finger moves a fraction of an inch, when you request the patient to move his hand," he says. "The important issue is that the command following behavior does not occur spontaneously in the patient, but only upon command."

In addition, the criterion is not met if the behavior occurs when a different command is given, he explains. "For example, if you ask a patient to blink his eyes, and he moves his hand, the criterion is not met."

- **Any incidence of a yes/no response.** "It doesn't matter if this response is accurate in terms of an appropriate 'yes' or 'no' response to a particular question," notes Giacino. "What is important in this criteria is that the patient nods or shakes his head reproducibly. This response must also be clearly different from movement attributed to an increase in muscle tone, or even a reflexive muscle activity. If you can dissociate the 'yes' and 'no' response from any other explanation it would meet the criterion."
- **Incidence of intelligible verbalization.** "This can be tricky at times," he says. "A patient may make a sound, such as 'ma,' and clinicians may wonder whether this was an attempt to say 'mom' or just a random sound."

To meet this criterion, the verbalization must include a consonant-vowel-consonant verbalization, he notes. "This means 'ma' wouldn't qualify, but 'mom' would qualify," says Giacino, adding the vowel-consonant-vowel verbalization is a distinction used at JFK Johnson and is not necessarily part of the Aspen statement. "The patient must make an intelligible word, but it doesn't have to be upon request."

- **Any incidence of movements or emotional behaviors that occur in response to specific stimulus.** "This is the most convoluted, but a

very important, criterion," he says. "These are responses to a specific stimulus that occur when the stimulus is present, but which don't occur in the absence of the stimulus."

He offers case managers six examples to clarify this criterion:

— **Emotional responses such as smiling or crying.** "We've had family members or care providers report that patients in a vegetative state can smile or cry. This alone is not enough to meet the criteria for a diagnosis of MCS. The smiling or crying must occur in response to a specific stimulus, such as the presence of the patient's family," he explains.

Giacino recalls a patient who appeared to be in a vegetative state two years post-injury. He completed a comprehensive evaluation of the patient at the request of the insurance company and found no evidence of consciousness. As he was preparing to leave, the patient's wife asked Giacino to watch a video of the patient listening to his wife read a letter from his sister out loud. "As his wife read his sister's note, the patient began to cry," he says. "I had spent an hour with him and seen no evidence of consciousness, but whenever she read the note from his sister, he cried. When she stopped reading, the crying stopped. If the crying had been random or spontaneous, it wouldn't have met the criterion."

— **Vocalizations or gestures.** "These must be a direct response to a particular stimulus not demonstrated in the absence of the stimulus. For example, you go to the patient's bedside, wave, and say, 'Hello.' Whenever you do this, the patient's wrist flexes in a wave-like gesture. The patient appears to wave, and this gesture never occurs under any other circumstances."

— **Ability to follow and reach for an object.** "An example of this is presenting an object and moving it from the patient's visual field to the left or to the right. As you move the object, the patient reaches to the correct side relative to the object. If you can demonstrate that the patient is reaching in the direction of the object and that this occurs with regularity, it is a good example of this criterion."

— **Attempts to touch or hold an object.** "To meet this criterion, the patient also must demonstrate some ability to discriminate what the object is," notes Giacino. "For example, if you hand the patient a coffee cup, the patient opens his fingers to reach around the cup. If you hand someone a pencil, the grasp necessary to hold it is different from the grasp necessary to hold a cup. There

More reading on states of consciousness

Joseph T. Giacino, PhD, associate director of neuropsychology for the Center for Head Injuries at the JFK Johnson Rehabilitation Institute in Edison, NJ, suggests case managers interested in further information on vegetative and minimally conscious states read the resources listed below.

• The Multi-Society Task Force on Persistent Vegetative State. Medical aspects of the persistent vegetative state. *N Engl J Med* 1994; 330:1,499-1,508, 1,572-1,579.

• The Quality Standards Subcommittee. Practice parameter: Assessment and management of persons in the persistent vegetative state. *Neurol* 1995; 45:1,015-1,018.

• Andrews K, Murphy L, Munday R, et al. Misdiagnosis of persistent vegetative state: Retrospective study in a rehabilitation unit. *BMJ* 1996; 313:13-16.

• Childs NL, Mercer WN, Childs HW. Accuracy of diagnosis of persistent vegetative state. *Neurol* 1993; 43:1,465-1,467.

• Giacino JT, Zasler ND, Katz DI, et al. Development of practice guidelines for assessment and management of the vegetative and minimally conscious states. *J Head Trauma Rehabil* 1997; 12:79-89.

• Giacino JT, Kezmarsky MA, DeLuca J, Cicerone KD. Monitoring rate of recovery to predict outcome in minimally responsive patients. *Arch Phys Med Rehabil* 1991; 72:897-901.

• Jennett B, Plum F. Persistent vegetative state after brain damage: A syndrome in search of a better name. *Lancet* 1972; 1:734-737.

• Plum F, Posner J. *The Diagnosis of Stupor and Coma.* 3rd ed. Philadelphia: FA Davis; 1982.

• Giacino JT, Kalmar K. The vegetative and minimally conscious states: A comparison of clinical features and functional outcome. *J Head Trauma Rehabil* 1997; 12:36-51.

• O'Dell MW, Jasin P, Lyons N, et al. Standardized assessment instruments for minimally-responsive, brain-injured patients. *NeuroRehabil* 1996; 6:45-55.

• Giacino JT, Zasler ND. Outcome after severe traumatic brain injury: Coma, the vegetative state, and the minimally responsive state. *J Head Trauma Rehabil* 1995; 10:40-56. ■

must be some differentiated finger or hand movement that demonstrates the patient is aware what type of object this is."

A vegetative patient cannot hold an object, he adds. "Stimulation of the palm may cause a release of the grasp reflex. However, a patient in a vegetative state can't make the adjustment needed to differentiate objects. This is why it is important to use different types of objects to test for this criterion."

Giacino recalls one patient who appeared to be in a vegetative state. "He was not following commands, but I took an object and stroked the side of his index finger with it. He lifted his hand up, felt where the object was, and grabbed it. A patient in a vegetative state will never do this."

— **Visual tracking or pursuit eye movements.** To meet this criterion, the patient must fix on an object in the environment with his eyes and sustain fixation on the object as it moves around in the environment, he says. "The question here is how long must the patient fixate on the object to constitute tracking. This issue is not addressed clearly in the Aspen statement. However, I think that other statements have required sustained fixation of a minimum of two seconds or 20-degree movement."

At JFK Johnson, clinicians require patients to sustain eye fixation through a 45-degree arc from midline in any direction, Giacino adds. "This is a very important criterion because it is often the first indicator that a patient is emerging from a vegetative to a MCS. We use a mirror, because the patient's own face is such a powerful stimulus. We move the mirror slowly 45 degrees in all directions. When a patient is capable of following this, you will not miss the response. It is just too clear."

— **Avoidance of barriers.** "This criterion often sounds strange, but there is a reason it is included," he says. He cites an example of a woman who never demonstrated any kind of function. She never spoke or gave any clear indication of conscious behavior. Yet when placed in a wheelchair, the patient could move around the hallway avoiding all obstacles.

"She continued to show no other signs of consciousness," he says. "I followed her for nine months post-injury. At that point, she was walking. She walked aimlessly. She never hit anything. She walked around the perimeter of a pool table. But, it was all aimless. What do you call this?"

The patient came very close to a vegetative state. "I think this patient captures the diagnosis of MCS. She was in this state due to a metabolic coma. I think it's likely that [the coma destroyed] her cortex, her seat of higher reasoning, but [she] was left with her lower structures, like basic sensory reactions and basic motor functions," Giacino says.

Accurate diagnosis = accurate prognosis

MCS is a newly defined condition, so data are scarce. JFK Johnson has published a study that compared 12-month outcomes for patients in a vegetative state to MCS patients. "When these patients came in one month post-injury, there was little discernible difference between the two groups," he notes.

However, when a functional disability rating scale was used to reevaluate the patients at three, six, and 12 months post-injury, clinicians found significant differences between vegetative and MCS patients in terms of recovery.

"We then made one other distinction," Giacino says. "We further defined the groups in terms of those whose consciousness disorder was caused by trauma and those whose consciousness disorder was not caused by trauma. We found the most striking improvement occurred in MCS patients whose condition was caused by trauma. The study must be reproduced but it gives us the ability to begin to say there is a clear separation in outcomes between vegetative and MCS patients."

In addition, he says, the rate of recovery is helpful in predicting outcomes. "How fast a person is changing is a powerful predictor of their final outcome, regardless of how poorly they were functioning when admitted to rehab." To determine recovery rate, subtract the patient's week-one functional disability rating score from the patient's week-four score to get a "change" score, he says. "A 1991 study found that patients with a change score of six or more points in the first month had significantly better outcomes than patients with lower change scores. It didn't matter whether the patient's functional disability rating scores were high or low, as long as the change score was high."

Case managers who insist that rehabilitation teams use new, more accurate diagnostic criteria for disorders of consciousness will make better decisions about treatment interventions and help reduce the incidence of misdiagnosis, Giacino says. ■

CMs must develop clear pain policies

JCAHO turns the spotlight on pain assessment

Pain is often called the fifth vital sign, but too often routine pain assessment is overlooked in treatment plans. Lack of routine assessment and adequate education about effective pain management leads to undertreatment of pain symptoms in many patients.

The Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, recently addressed the need for more effective pain management by revising its standards for managing pain in all settings, including the acute, ambulatory, home care, long-term care, health plan, and health system settings.

"Unrelieved pain causes needless suffering and delays healing. Case managers have a vital role in improving pain management. One of the largest barriers to managing pain effectively is that nurses, doctors, and pharmacists receive little formal education in this area," says **Carol P. Curtiss**, RN, MSN, OCN, clinical nurse specialist consultant in Greenfield, MA, and past president of the Oncology Nursing Society in Pittsburgh.

"We make decisions every day as part of our practices," she explains, "but we haven't learned enough about good methods of pain assessment and management."

The first step in a pain management plan is an honest appraisal of the patient's pain, adds **Mark A. Young**, MD, FACP, associate chairman of physical medicine and rehabilitation at New Children's Hospital and the Bennett Institute for Sport's Medicine and Rehabilitation and associate co-director of rehabilitation at Maryland Rehabilitation Center, all of Baltimore. "Every patient is different. At the very onset, the physician must establish a clear and accurate picture of the pain."

Young recommends case managers look for the following elements in a thorough pain evaluation:

- a chronological history of the pain;
- activities, treatments, or events that make the pain better;
- activities or events that make the pain worse;
- ability to perform activities of daily living;
- underlying disease processes that cause or contribute to pain or the perception of pain;
- the quality of the pain,such as sharp, dull, radiating or localized;
- therapies tried in the past for pain relief;
- a complete list of medications taken for pain and other conditions.

"There also must be a clear understanding of the psychosocial issues that go along with the patient's pain," he says. "The physician and the case manager must be very directed and targeted and even obsessive at times in obtaining a good pain history. The history guides the future treatment plan and sets the tone and stage for an effective pain management regimen."

Young says these psychosocial issues should be included in a pain evaluation:

- family dynamics;
- work situation;
- emotional cycles;
- history of treatment for depression or other psychiatric disorders.

Show me where it hurts

A pain diary and body mapping diagrams, which chart the areas affected by pain, also are crucial elements of a pain management evaluation and treatment plan, note Curtiss and Young.

"Patients generally come in for initial evaluation and then are typically seen again by the physician a week or two weeks later. A pain diary helps the physician see patterns of pain and pain relief throughout the week and develop a more effective pain management plan," Young says.

Even many cognitively impaired patients can be taught to use a simple pain severity scale, body diagrams, or visual analog scales, say Curtiss and Young. These scales usually use a number range from zero to 10 to rate pain severity, where zero is no pain and 10 is the worst possible pain. Analog scales use faces with expressions ranging from smiling to severely distorted to demonstrate pain severity.

"Once a client is taught how to use a pain severity scale, it's an easy task for the case manager and the treating physician to determine when pain is a problem for the patient," Curtiss says. "Patient self reports of pain and of pain relief go hand-in-hand. If you are only asking your patients to measure their pain, you are only receiving a piece of the picture. You must also evaluate the effectiveness of the interventions that are in place."

If your patient has difficulty understanding how to rate pain on a severity scale, try using an

analogy, she suggests. "I have a friend who works in the long-term care setting. She has her cognitively impaired patients pretend they are driving a car. She tells them to imagine their pain as a speedometer. She instructs them to imagine zero as no pain and 100 miles an hour to be the worst pain possible. Then she tells them push down on the gas pedal and tell her where the speedometer stops."

Even case managers who work exclusively or predominately with patients via telephone can and should effectively assess pain symptoms, Curtiss says. She suggests that case managers ask patients the following questions about their pain symptoms:

- What is the worst your pain has been today?
- What is the best your pain has been today?
- What have you done that made your pain worse?
- What have you done to manage your pain? Has it made a difference? How much relief did it provide on a scale of one to 10?
- What is your pain preventing you from doing?
- What are your goals for pain management? On a scale of zero to 10, what level of pain would let you go about your daily business?

"Asking questions over the phone and assessing the outcomes of your patient's pain management efforts gives the case manager a decent picture of whether the patient's pain symptoms need further investigation," Curtiss says.

She also suggests case managers instruct patients to call them to report the following:

- any experience of new pain;
- any worsening of pain;
- any pain above level five on a zero to 10 rating scale;
- any level of pain unacceptable to the patient;
- lack of bowel movements for two or more days in patients who are using opioids.

"This last bullet gives patients permission to call you for other reasons, including I'm afraid to take this medicine," says Curtiss.

Often the biggest obstacle case managers must overcome in advocating for more effective pain management is the fear common to both physicians and patients that use of certain pain medications may lead to addiction, say Young and Curtiss. " I could just beat my head against the wall sometimes over that one issue," Curtiss says. "There is a fear of use of opioids when, in truth, appropriately used, the risk of addiction with these drugs is less than 1%."

The important thing is for case managers to explain to patients, families, and, if necessary, physicians, the differences between physical dependence, tolerance, and the psychological drug-seeking behavior associated with addiction, she says. **(For more on appropriate opioid use, see *Case Management Advisor,* Sept. 1998, pp. 151-155.)**

"There are a number of physicians uncomfortable using more heavy-duty medications due to lack of information about proper prescribing habits," Young says. "They fear subjecting patients to addiction potential."

However, there is little danger of addiction to pain medications if physicians follow guidelines established by the Agency for Health Care Policy and Research in Silver Spring, MD, which outlines a disease management approach to chronic pain, Young says. "It's a stepped-up approach which starts at the safest and least addictive options and progresses to more powerful drugs, only as needed."

Setting standards for care

She adds that it's important for both payer- and provider-based case management programs to have a clear pain management policy. "It's difficult to know if you are managing pain well if you don't have a written standard of care that defines pain management. In addition, most health insurers have no clear-cut policies for reimbursement for pain relief. This leads physicians to err on the side of caution and leaves patients undertreated."

"The nice thing about developing a pain management policy is that the standards are clear among organizations about how to assess and manage pain," she notes. **(See insert for a list of resources you may use to develop a pain management policy. Also, see story on acupuncture for pain management, p. 65.)**

Curtiss recommends case managers include these elements in their own pain management policies:

- systematic and ongoing assessment of pain symptoms;
- minimum required assessment frequency of once each visit in the home care setting and once each shift in the inpatient setting;
- standard for the level of pain that requires a review of the pain management plan;
- systematic use of appropriate pain medications;

• evaluation of the effectiveness of pain medications;
• combining pain medications with non-drug therapies, such as heat, cold, relaxation, and imagery;
• measuring pain management outcomes;
• ongoing quality improvement assessments.

Curtiss has given presentations on pain management in 41 states and nine countries. She often shares a quote from a pain patient who came forward to talk to her after one presentation. "I had shown a slide with a quote from a terminal cancer patient who said, 'When you treat my pain, you help me forget I have cancer.' The patient who came up to me was also a cancer patient, but not considered terminal, he said, 'You have to tell the other side of the story. When you treat my pain, you free me to fight my cancer.'" ■

Acupuncture provides effective relief

Ancient therapy may reduce need for surgery

American clinicians still have a great deal to learn about the use of non-drug interventions for pain management, say two experienced pain consultants. However, one non-drug therapy, acupuncture, is gaining ground with physicians as a viable alternative or adjunct therapy to drug intervention.

"I have had patients who have achieved excellent results with acupuncture, especially for the pain, nausea, and vomiting associated with cancer treatment," says **Carol P. Curtiss**, RN, MSN, OCN, clinical nurse specialist consultant in Greenfield, MA, and past president of the Oncology Nursing Society in Pittsburgh.

"Acupuncture can help amplify, or enhance, a patient's response to pain relieving drugs by using meridian patterns in the body which cause a release of endorphins, the body's natural pain reliever," explains **Mark A. Young**, MD, FACP, associate chairman of physical medicine and rehabilitation at New Children's Hospital, associate chairman of rehabilitation at the Bennett Institute for Sport's Medicine and Rehabilitation, and associate co-director of rehabilitation at Maryland Rehabilitation Center, all of Baltimore. "Case managers should be interested to know that many patients respond dramatically well with acupuncture, and thousands of dollars can be saved by avoiding the need for further surgery."

Young, a licensed acupuncturist, recommends acupuncture be introduced after week two or three in patients who are responding to their pain management plan with limited or moderate success. "Acupuncture is a harmless technique with dramatic pain relief potential when started fairly early in a patient's pain management treatment. Chronic pain patients should receive weekly sessions for a minimum of five weeks to afford an adequate period of time to establish release," he says. "Clinicians generally know early on whether a patient is experiencing a positive response to acupuncture. The patient reports an almost immediate improvement in well-being." **(For more on pain management, see p. 63. For sources of information on the use of acupuncture for pain management, see reading list insert.)**

Releasing natural pain killers

Acupuncture often arrests the pain-spasm cycle that characterizes the pain in patient's life, Young says. "Acupuncture sessions performed in a series promote a release of the body's natural pain killers and levels the playing field. It allows the body to rest and heal. I must add that we don't yet understand the mechanism of action in acupuncture, yet those of us who use acupuncture in our practices often see dramatic results."

Patients who generally respond well to acupuncture include those with:
• low back pain;
• migraine headaches;
• shoulder and neck pain.

He cautions that patients will experience changes in appetite and energy levels during acupuncture therapy. "Patients become tired during their sessions. They also may experience migration of their pain."

Case managers should approve acupuncture and pain management strategies early on, he says. "If case managers approve the use of pain management strategies, such as acupuncture, at the onset of a case they may avoid subjecting patients to a surgical approach that's not absolutely necessary. There are clearly times when surgery is the only option. However, in many cases, I have been able to save insurance companies thousands by affecting a spontaneous improvement in pain intensity with acupuncture." ■

Guest column: Long-term care/geriatrics

Help elderly clients conquer loneliness

By **Ruth Shearer**, RN, MS, MSN
Assistant Professor, Division of Nursing
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Everyone experiences occasional bouts of loneliness. Even more common among the elderly, loneliness often contributes to depression and may lead to physical or cognitive decline in elderly clients.

Your elderly clients may experience loneliness in different situations. Many women outlive their spouses, and even when a spouse is alive, loneliness often enters the picture. Feelings of loneliness may occur when a spouse needs hospitalization, nursing home placement, or when a spouse becomes confused and unable to carry on a normal conversation. Similarly, your elderly client may experience loneliness during a hospital stay or during rehabilitation from an illness or injury.

Know the signs

Loneliness also can be a symptom of depression. Even as you consider developing a care plan to alleviate feelings of loneliness in your elderly clients, you must be alert to signs of clinical depression, including refusal to eat, diminished concern about personal appearance, and reluctance to make decisions.

Medical referral for clinical depression is imperative because there are medications and other interventions that effectively alleviate feelings of sadness and despair characteristic of clinical depression. **(For a list of articles on depression assessment, see box, p. 67.)**

Case managers must determine whether loneliness is a symptom of depression or an emotional state that can be changed. If you have ruled out clinical depression, teaching elderly clients the strategies outlined in this column may help them conquer loneliness and improve their quality of life.

1. **Express and work through grief for lost loved ones.** Everyone experiences loss. Feelings of loss, depression, anger, and grief must be spoken so that they can be left behind. Encourage your elderly clients to discuss the loss of loved ones. After a period of grieving, encourage your elderly client to reach out for new friendships, fresh experiences, and new kinds of activities.

Suggest community programs and support groups that can provide your elderly client an opportunity to meet other older adults with similar interests.

2. **Get involved in new kinds of work and activity.** Getting involved in new work and activities, paid or volunteer, opens new horizons for elderly clients. Provide your clients with a list of volunteer opportunities close to home. Encourage them to pursue hobbies, either new activities or ones they have enjoyed in the past. Research data suggest that activities offset the disenchantments that come when jobs are boring or lost, or even when a loved one dies.

3. **Get involved in new relationships.** Connecting with others through mentoring, caring about them, and being involved in a meaningful way fosters feelings of contentment. Some suggestions for building meaningful, new relationships include returning to school, starting a new career, rediscovering creative pursuits, and traveling.

4. **Learn new patterns of behavior.** As individuals age, they experience a number of losses. In addition to the loss of loved ones, disabling illness, and boredom may lead to feelings of loneliness and depression. Learning a new skill provides challenges. It also helps create a positive mind-set in older adults. Ask your elderly clients about interests and suggest adult education classes and other activities that encourage them to master new skills.

5. **Learn to live alone and like it.** Family members and spouses leave or die throughout life. Each person will live alone at times. Living alone does not have to be lonely. Encourage elderly clients to live near family members and friends so they can be included in activities. Children enjoy interactions with older relatives through letter writing, telephone calling, and visiting.

In addition, suggest that family members send your elderly clients newspaper, clippings, coupons, photographs, and mementos of special events. Your clients may want to save some of these newspaper articles in a scrapbook highlighting family activities and accomplishments.

One of this column's authors has an elderly aunt who lives alone. The aunt compiled scrapbooks over the years filled with newspaper clippings and other mementos she received from the author. The aunt sent those scrapbooks to the author, who was preparing to apply for a fellowship in the American Academy of Nurses. Many items in the scrapbooks became documentation of professional activities. The aunt was able to provide a unique service that promoted a professional career.

6. **Change expectations and goals.** Clients with the ability to change their expectations and goals with age are happier in later adulthood. Encourage elderly clients to identify and use qualities that may have lain dormant.

In addition, instead of waiting for children living out of town to visit, encourage elderly clients to regularly visit a homebound neighbor, friend, or member of their religious community. These visits will alleviate your clients' loneliness and will give them a sense of purpose.

7. **Cope creatively with stress.** Individuals can choose their subjective mental state. For example, instead of acting devastated by a loss, an individual can choose to view it as a learning experience. That experience can be shared with others, thus turning a loss into something positive. The ability to bounce back following a stressful event and to maintain a positive attitude is an important protection against feelings of loneliness and despair.

8. **Use reminiscence to enjoy the past.** Reminiscence promotes ego integrity, pleasure, and hope. Personal reminiscence of pleasant memories produces pleasure and is useful in alleviating loneliness. Suggest that your elderly clients surround themselves with items from earlier, happier days.

Special items, such as a desk used by a spouse who has died, can bring pleasant memories into a room. Pictures of family members and friends serve as a symbolic representation of caring, provide meaning to life, and reduce feelings of loneliness. Pictures also stimulate discussion of

More reading on loneliness, depression among the elderly

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personal pride that include personal and family accomplishments.

9. **Seek help to deal with situational stress and change.** Situational stresses, losses, and changes can cause temporary feelings of grief. Encourage elderly clients to seek support from a person who is an active listener, or be an active listener yourself. Simply having someone listen to their concerns may enable your elderly clients to cope more effectively.

Being heard also fosters an expectation of being helped. This expectation of help decreases anxiety, as well as feelings of loneliness. There is therapeutic value in discussing a problem. In addition, telling someone else, such as a case manager, care provider or family member, about a problem also may enable your client to begin solving it.

Case study: Edith

The case of a woman named Edith illustrates how many of the strategies discussed in this column alleviate loneliness in the elderly. Edith lost her husband when she was 70. This loss did not daunt her spirit. She remained active in her church and its women's group activities.

Edith's widowed sister moved in with her to provide companionship. The sisters traveled each summer from their home in Florida to a lake cottage in Indiana and then on to Pennsylvania to visit their children and grandchildren. Edith continued to be happy, concerned about others, and persistently invited family and friends to visit her Florida home.

At 78, Edith married a widower named Bill. Bill and Edith spent winters in Florida and summers in Indiana at the lake. They also traveled to Alaska, Hawaii, and across the United States. The couple invited family and friends to visit them in Florida. They made themselves available as hosts and tour guides.

When Edith was 92, her second husband died. The funeral was a celebration of the many positive relationships Bill had developed and the wonderful memories shared by Edith and Bill's large extended family. At the funeral home, Edith continued to greet friends and family with warmth and enthusiasm and to invite them to visit her when they were in Florida. Edith and Bill conquered loneliness throughout their lives through the warm and positive relationships they maintained. ■

CE objectives

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

1. Develop a pain management policy.
2. Communicate more effectively with physicians and patients about pain.
3. Differentiate between minimally conscious and vegetative states.
4. Implement strategies to reduce loneliness in the elderly.