AMERICAN HEALTH CONSULTANTS®

Case Management ADVISOR™

Covering Case Management Across The Entire Care Continuum

INSIDE

JUNE 1999

VOL. 10, NO. 6 (pages 85-100)

American Health Consultants® is A Medical Economics Company

Professional development

Health care organizations must support CM education

No continuing ed means no CCM; no CCMs means no accreditation

The want ads reflect the value health care organizations place on well-prepared case managers. Supervisors of case management staffs nationwide are seeking case managers with BSNs and the CCM, or certified case manager certification, from the Commission for Case Management Certification (CCMC) in Rolling Meadows, IL.

Although they demand case managers come to them with the highest credentials, too many health care organizations fail to support their case managers' efforts to maintain high professional standards. For example, many employers make it virtually impossible for case managers to complete the 80 hours of continuing education required every five years for CCM recertification.

"It's to the employers' benefit to allow case managers the time and resources necessary to maintain their certifications," notes **Marcia Diane Ward**, RN, CCM, project manager in small/medium business global marketing industries for IBM in Atlanta. "The benefit is that employers go out to market their services with this statement: 'We hire only certified case managers.' Increasingly, health care organizations can't sell their case management services — or receive accreditation for them from national accrediting organizations — unless their staff includes certified case managers. They are literally out of business unless they have a CCM on staff."

However, there are complications, adds **Deloras Jones**, RN, MS, director of divisional nursing for Kaiser Permanente California Division in Oakland. "At the same time the technical demands of the health care industry require more educated nurses, we have declining enrollment in our nursing baccalaureate programs nationwide," she says. "It's a real dilemma. We need nurses who are better educated to meet the complex and changing roles in the industry, such as case management. And we have an entire generation of nurses close to retirement without an

adequate supply of properly prepared nurses to take their places."

Case managers must work with their employers to find creative ways to support their professional development efforts, say Ward and Jones. Here are five suggestions to help case managers meet their education needs and, in doing so, benefit their employers' marketing and quality improvement efforts.

1. Set aside dedicated funds early in the fiscal year to pay for conference and workshop attendance. "Conference planners are now making concessions for the financial crunch faced by case managers," notes Ward. "Some conferences offer one-day passes, discounts for more than one attendee from the same organization, and other incentives. Don't be afraid to ask about potential discounts. Barter, if you must. No one is more creative than a case manager at negotiation — use it to your own advantage."

2. Allow time off to attend local chapter meetings of your professional organizations. State and local chapters of national professional organizations, such as the Case Management Society of America in Little Rock, AR, offer inexpensive continuing education opportunities, Ward says. "These groups usually meet once a month, and they bend over backwards to accommodate employer schedules," she says, adding that many groups meet early in the morning or on Saturday.

3. Hire a clerical support person or allow a case manager time to search the Internet for educational opportunities. "Try to get your employer to pay a case manager overtime to gather information on the Internet and then share it with other case managers at a lunch-and-learn session," Ward suggests. "Many case managers don't have the time to surf the Internet for the many educational Web sites. Some of these sites offer continuing education credits for health care professionals."

4. Provide educational opportunities in the workplace. Kaiser now offers an affordable, convenient program for its nurses with associate's degrees who want to advance their careers by earning a BSN, Jones says. The nursing degree program is a joint effort between Kaiser's California Division and Holy Names College in Oakland. Instead of hurrying from work to a college campus for studies, students attend classes one night a week via teleconference in classrooms at the Kaiser medical centers where they work.

"We already had the teleconferencing network. That made establishing the nursing program very easy," Jones says. "The instructor comes to a central location and the class is broadcast via our video network to various Kaiser campuses."

Since the program began, 96 Kaiser nurses have earned their BSN degrees and 200 currently are enrolled in classes. "It takes most of our nurses two and one-half years to complete their degrees," Jones says. "Kaiser doesn't pay for nurses' tuition, but we were able to negotiate a low rate because the program is generating revenue for the college."

In addition, Kaiser offers continuing education courses for no fee or a nominal fee to its nurses on a routine basis. "It's really important for leaders in the health care industry to partner with educators to ensure the ongoing competencies of their work forces."

"The BSN degree program teaches nurses the critical thinking and problem-solving skills they need to move into more complex roles where they can make decisions regarding patient care delivery," agrees **Maureen Asamiquela**, RN, PhD, director of educational partnerships and distance learning for Kaiser. "Most nurses who get their BSN degree go on to receive master's-level training, which enables them to become nurse practitioners and nurse managers," she adds.

Kaiser offers its nurses a master's in nursing through Sonoma (CA) State College. "This program is also offered over the teleconferencing network. Nurses can earn a master's in nursing leadership or case management," says Jones, adding that 50 Kaiser nurses are enrolled. **(For more on distance learning, see *Case Management Advisor,* December 1998, salary supplement.)**

COMING IN FUTURE MONTHS

- How to defend yourself if you join the growing number of CMs in court
- Safely integrate complementary and alternative medicine into care plans
- Hospitalists and CMs: What does the future hold?
- New strategies for identifying and managing high-cost cases
- When benefits run out, tap into the Brain Injury Trust

The master's program recently was expanded to add an Internet-based program, as well. The bachelor's and master's programs are open to the community.

5. Subscribe to publications that offer continuing education hours. Take advantage of continuing education opportunities available through professional publications. "Many case management and nursing publications offer continuing education credits," notes Ward. "It's not as stimulating as networking with your peers at conferences, but if your organization doesn't allow you time off to attend professional meetings, these publications may be a viable option for you."

"We are on the verge of a serious shortage of qualified nurses in this country," Jones says. "If health care organizations want to meet the changing needs of health care, they must support the education efforts of their nurses. As a nation, we must change the way we view and value nursing as a profession."

"Case managers must reclaim their autonomy as professionals," Ward urges. "Your employer needs you to maintain your certifications and professional licenses, and that requires continuing education. Explain that continuing education is not an option — it's a necessity."

Managed care organizations can't get licensed or receive accreditation from the Joint Commission on Accreditation of Healthcare Organizations without a CCM on staff, Ward adds. "A simple reminder of those facts may make your employer more willing to support your education needs." ■

Get your pencils ready

It's time to prepare staff to push paper

If your case management software fails on Jan. 1, 2000, would you know how to complete a client intake, file necessary paperwork, or find the proper diagnosis codes? An important part of your year 2000 (Y2K) contingency planning is to identify the systems and tasks essential to your job and then figure out how to complete the necessary work without the systems you've come to rely on, says **Elizabeth H. Wheeler**, RRA, a management consultant with Superior Consultants, a health care information systems and management consulting firm in Southfield, MI.

Here's her four-step planning guide for your final countdown to New Year's Day.

1. **Know your organization's mission.** "Your Y2K contingency plan must be geared toward supporting your organization's mission," Wheeler says. "Without a clear understanding of the mission, you can't properly identify the systems and products necessary to meet the mission goals."

2. **Identify systems necessary to fulfill the mission.** "You must identify all the systems used to support the organization's mission," she notes. "This will be an individualized list specific to each case management department or company."

3. **Rank systems in order of importance.** "Within any organization, there are not enough dollars available to replace, upgrade, or change every system that may require it for Y2K compliance," Wheeler says. "You have to develop an arbitrary ranking system that somehow matches each business function and the systems needed to perform it with the organization's mission."

Your ranking system could be based on a scale of one to three with three being very important and one being not important at all, she notes. "Assign a rating from your arbitrary scale so that each product, process, and system holds a value that enables the risk severity to be assessed and documented."

Y2K: The countdown continues

If you think you've heard enough about the millennium bug, consider these findings from a recent survey by Weiss Ratings in Palm Beach Gardens, FL:

- 253 of 984 (25.7%) insurance companies surveyed about year 2000 (Y2K) preparedness report inadequate progress.
- Of those, 118 (12%) were assigned a Y2K grade of "below average," and 135 (13.7%) received a grade of "low."
- Only 8.3% received a "high" grade.
- The remaining 66% rated "average."

The survey asked 13 questions about each company's time line for completing Y2K remediation plans and critical tasks using national standards set in September 1998 by the insurance industry. This special report will help you complete your own Y2K countdown. ■

It helps if case managers look at risk assessment in terms of the exposure their organizations would face in the event of a Y2K failure. "Your rating scale should, in effect, be a description of the impact of that system failing," Wheeler explains. "If a piece of medical equipment necessary to properly care for a patient fails, that naturally holds a higher risk exposure than if there is a temporary interruption of revenue due to a system failure."

4. **Write contingency plans.** "You must develop contingency plans that support the continuation of every function you identified as essential to supporting your organization's mission goals," she says. "There has to be a plan in place for performing functions in a backup fashion."

For example, if your case management software fails, you still could complete notes by hand. However, are you prepared for the additional time completing patient paperwork by hand requires?

"If your electronic systems fail, you may need additional people to complete the same amount of work in the same amount of time," she says. "This is the time to contact local temporary services to arrange for temporary staff. You may have to offer a retainer to get on their list, and if you need specialists, there may be fierce competition for those services."

Also, if your case management staff are predominately younger than 40, they may not know how to complete tasks manually, Wheeler cautions. "This is the time to do some staff training on how to do things the old-fashioned way. For example, do your case managers know how to use a code book to find diagnosis codes?"

Wheeler stresses coding with all of her health care clients. "We're finding that people are so used to using electronic systems for coding that they have forgotten how to use coding manuals. And remember that coding manuals really can't be shared. If you hope to keep your productivity up, each employee needs a coding manual. If you don't have them, don't wait until October to order them, they may not be available."

Most organizations will be without their systems only for a few days, possibly weeks, Wheeler notes. "However, be sure to think through your contingency plans thoroughly. Some of the things you may think are going to be your backup systems may or may not be available to you. For example, if you can't rely on electronic exchange of information, you may plan to use a courier service. However, if you cover a large geographic area, a courier service may not be practical or timely enough for your needs."

And, of course, document all of your Y2K compliance efforts, she urges. "The first thing attorneys will ask you to show them in the event a failure results in a lawsuit is all the documentation that shows you made an effort to obtain compliance information from all of your vendors and trading partners and plan properly for potential failures. Remember, if it isn't documented, it didn't happen. You can't prove you made an effort unless you keep careful notes." ■

Food for thought

Roughly 25 billion microchips, or embedded systems, exist worldwide. If even one-tenth of 1% of those 25 billion chips are year 2000 defective, a staggering 25 million repair jobs will be needed on Jan. 1, 2000.

Source: Yourdon E, Yourdon J. *Time Bomb 2000, What the Year 2000 Computer Crisis Means to You.* New York City: Prentice Hall; 1998.

Don't overlook embedded technology

In the rush to deal with computer hardware and software-related year 2000 (Y2K) issues, the embedded technology problem often is overlooked, says **Sandra K. Bell**, an attorney and Y2K consultant in private practice in Atlanta.

Embedded technology, which can be found almost anywhere, refers to everything from a microchip to a complex, integrated hybrid system. This technology provides the intelligence associated with process control systems and frequently interfaces with application systems.

Medical equipment Bell says may not be Y2K compliant includes:

- pacemaker monitors;
- monitoring equipment, such as cardiac monitors;
- defibrillators;
- automatic medication dispensing equipment;
- enteral pumps;
- digital thermometers and scales;
- pulse oximeters.

In addition, Bell notes that many systems important to the comfort and safety of your patients may not be Y2K compliant. Those include:

- fire and burglar alarms;
- heating and cooling systems;
- thermostats;
- continuous power supplies;
- refrigeration systems;
- carbon monoxide monitoring systems;
- humidity / temperature monitoring systems.

"This problem may be even more critical because it will occur in the middle of winter where the potential for severe weather compounds problems associated with system failure," she says. **(For information on how to test for Y2K compliance, see *Case Management Advisor,* Jan. 1999, pp. 1-9.)**

(Editor's note: Sandra K. Bell can be reached via e-mail at bell-law@mindspring.com.) ■

Take four steps closer to compliance

The American College of Physicians and the American Society of Internal Medicine (ACP-ASIM), both in Washington, DC, offer on-line assistance for your Y2K preparation efforts at www.acponline.org / y2k. The groups' Y2K information center contains a complete list of resources to assist you in dealing with the millennium bug, including the following:

- a guide for replacing non-Y2K-compliant equipment;
- a list of four first steps to take as well as four steps to avoid;
- a guide for checking Y2K compliance of medical devices and business support systems;
- links to outside sites offering free vendor inquiry form letters;
- software for testing hardware;
- compliance reports on specific medical and other devices.

"Precious little time remains in which to correct Y2K problems," warns **Carol Cunningham**, director of the ACP-ASIM's Center for a Competitive Advantage. "Any delay could mean you will miss the deadline for correcting your systems due to vendor backlogs in providing updates and replacement software." ■

More cyber news: Records' privacy concerns patients

Where are you on the information superhighway?

There's little doubt that Americans are commuting daily on the information superhighway. For case managers, the commute presents both opportunities and threats for themselves and their patients.

For example, a recent survey conducted for the California HealthCare Foundation in Oakland found that Americans trust their doctors and hospitals with confidential medical information, but they fear disclosure when that information is handled and stored by private health insurance plans. Computerization and electronic transfer of medical records were seen as the most serious threats to medical privacy by the 2,100 consumers surveyed.

Other findings include the following:

- 54% of respondents said they believe the shift from paper record keeping to computer-based systems makes it more difficult to keep medical information confidential.
- 55% said they worry more about computer hackers breaking into electronic medical records.
- 30% said they worry about authorized users leaking private medical information.

You are here

An unrelated survey on Internet use by health care managers conducted recently by Cut to the Chase, a health care management information firm in Watertown, MA, found that when it comes to racing down the superhighway, managers in acute care settings are way out in front.

Asked about their Internet access at work, only 37% of managers in long-term or subacute care reported having access, compared with 76% of their colleagues in acute care settings. Other findings include:

- 73% of managers in medical practice groups reported having Internet access at work, compared with 57% of managers in home health.
- 43% of home health managers and 60% of long-term and subacute care managers report having Internet access at home only.

For more details on the Internet study, visit the company's Web site at www.cuttothechase.com. Or call (617) 926-3177. ■

Survey finds patients want the truth

Disclosure empowers patients

Press, Ganey Associates in South Bend, IN, recently compiled data from 250,000 patients in 476 hospitals and found that the majority wants the cold, hard facts about life support and organ donation.

"When health care organizations share information regarding life support options and organ donations, what they are doing is admitting the possibility of an adverse outcome. While it was once believed that patients would cringe during a discussion relating to the possibility of mortality, the truth is that by doing this, health care organizations are creating a collaborative atmosphere that empowers the patient," says **Irwin Press**, PhD, president of Press, Ganey. "The results of this study clearly show that by bringing patients into the reality of health care, we're serving and satisfying them — not intimidating them."

Given the option . . .

The survey questionnaire asked patients whether the hospital provided information on organ donation and on the choices available for continuing life. The survey found:

• 85% of patients who received information about life-continuation options were satisfied with their care provider, compared with 81% of patients who did not receive information about life continuation options.

• Nearly 86% of patients who received information about organ donation were satisfied with their care provider, compared with roughly 82% of patients who did not receive information about organ donation.

"When we look at the satisfaction of patients who tell us they received information of this sort, it is clear that their assessment of the health care experience does not diminish," Press says. "Instead, patients who report receiving information are significantly more satisfied than those who did not."

(Editor's note: For additional information, visit Press, Ganey Associates' Web site at this address: www.pressganey.com.) ■

Disease management/managed care

Plan rates MDs on asthma care in new report

Plan hopes report will boost compliance

Health Net, California's second-largest health plan, with 2.2 million members, released what is believed to be the first chronic disease-specific report card. When the report cards were mailed, most of the health plan's 47 medical groups received grades of C or below for asthma care. To be precise, nine groups were rated above average, 32 were rated average, and six were rated below average.

Health Net surveyed 5,580 patients enrolled for a year or more identified through the plan's pharmacy database as having received prescriptions for inhaled corticosteroids, beta-antagonists, or theophylline. Patients who received prescriptions for those medications but indicated they were not being treated for asthma were excluded from the survey.

The survey asked a series of questions about symptoms, treatment, knowledge of disease self-management, use of medical care, and satisfaction with care. It also measured the following eight areas of function on a scale of 0 to 100:

(Continued on page 95)

Asthma soars in U.S.

If you're still wondering why so many health care organizations focus their disease management efforts on asthma, consider these facts from an April 1998 report from the Centers for Disease Control and Prevention (CDC) in Atlanta:

- Asthma prevalence has increased by 75% since 1979.
- Asthma prevalence in children under age 5 has increased by 160% since 1979.
- The CDC predicts the asthma prevalence rate will continue to increase by 5% a year.
- The asthma death rate among blacks climbed by 130% between 1979 and 1995.
- The asthma death rate in whites climbed 86% between 1979 and 1995. ■

(Continued from page 90)

- perception of general health;
- physical functioning;
- social functioning;
- limitations due to physical conditions;
- limitations due to emotional conditions;
- limitations due to bodily pain;
- limitations due to mental health;
- limitations due to fatigue.

Among the study's more disturbing findings are these:

- Only 72% of Health Net's patients with severe asthma reported having a steroid inhaler and, of those, only 54% used it daily.
- Only 26% of patients with severe asthma reported having a peak flow meter and, of those, only 16% reported using it daily.

The National Asthma Education Program of the National Heart, Lung, and Blood Institute in Bethesda, MD, published its *Guidelines for the Diagnosis and Management of Asthma* in 1991. Although those widely disseminated guidelines clearly recommend the use steroid inhalers, the survey results indicate that most primary care physicians still are not routinely prescribing daily steroid inhaler use for patients with chronic asthma, notes **Darius Jatulis**, MS, senior statistician and manager of the quality initiatives division of Foundation Health Systems, Health Net's parent company in Woodland Hills, CA.

"Our survey found that asthma specialists provided more thorough care than did primary care physicians in treating patients with asthma," adds **Antonio P. Legoretta**, MD, MPH, vice president of the quality initiatives division of Foundation Health Systems. "Patients who received care from an asthma specialist reported higher levels of compliance with prescribed management programs and better outcomes, as well as higher satisfaction with the treatment of their condition.

"We collected and published the data for several reasons," he says. "First, we wanted consumers and employers to be able to see which medical groups have a better track record for asthma care so that they could make provider decisions based on empirical data. Second, we wanted the report card results to motivate providers to improve their performance on asthma care."

Health Net mailed its Asthma Care Report Card to each of its medical groups and some employers who were especially concerned about asthma, says Jatulis. In addition, Health Net members can request a personal copy of the report.

The report card issues an asthma care score or ranking for each medical group. "It shows the asthma emergency department admission rate, hospitalization rates, peak flow meter use among the group's asthmatic patients. It gives the rankings and results to decision makers in the health care marketplace," he notes.

In the meantime, Health Net took immediate action to improve asthma care for the roughly 5,000 members identified as having severe asthma. The plan sent peak flow meters and educational materials to each of its severe asthmatics. Health Net also hired a nurse educator to call a subgroup of its most severe asthmatics weekly to help remind them to use their peak flow meters and asthma medications.

Health Net plans to release similar report cards for other chronic conditions in the future, Jatulis says. "We're already moving forward to do a similar report for maternity care."

Providers get a peek

Although Health Net mailed its Asthma Care Report Card to the plan's medical groups, providers were given an opportunity to see preliminary findings and improve their scores before the final report was published, he says. "To help us get providers on board with this effort, we showed them their scores for a one- or two-year period prior to disseminating the scores. We gave providers the data first. We gave them the opportunity to respond, to react, and to test our measurement system. For example, depending on how they code for certain diagnoses or procedures, we might be measuring them unfairly."

Jatulis urges other health care organizations to start similar programs. "It's well worth the effort it takes to do the surveys. It provides a documentable, value-added service to your customers. It also offers your providers an opportunity to improve the care they deliver your members. We have a vantage point to look at different providers and examine variability. Individual provider groups may be working in a vacuum and be unable to see where they stand relative to their peers."

[See also: Legorreta AP, Christian-Herman J, O-Connor RD, et al. Compliance with national asthma management guidelines and specialty care. *Arch Intern Med* 1998; 158:457-464. Jatulis DE, Meng YY, Elashof RM, et al. Preventive pharmacologic therapy among asthmatics: Five years after publication of guidelines. *Ann Allergy Asthma Immunol* 1998; 811:82-88.] ■

Survey finds allergies cost employers most

Allergies cause staff to lose 3.2 days a month

Ever wonder if you're allocating your disease management resources effectively? The findings of a new study of Florida employers may surprise you.

The study found that allergies cost employers nearly $1.4 million per 1,000 employees annually in lost productivity alone, more than any other medical condition. The recently released Healthy People / Productive Community survey was conducted by two Tampa-based companies, the Employers Health Coalition and the Employers Purchasing Alliance.

The eye-opening data gathered from more than 3,500 employees of eight large Tampa-based employers has those employers looking to their health plans and local providers for help with allergy management.

Sneeze productivity goodbye

Surveys often measure health plan member satisfaction or track medical claims. The Healthy People survey relied on employees to report what ails them and how much they are affected by those ailments, says **Frank Brocato**, MSHA, DMin, president and CEO of the Employers Health Coalition. The survey is a second-generation tool, which followed an earlier measurement that identified the most prevalent disease among employers, he adds.

Allergies topped all other conditions in costs due to lost productivity. Nearly 28% of employees surveyed reported suffering from allergies. Those employees reported losing an average of 3.2 days every four weeks due to lowered productivity caused by allergy symptoms, and another one-tenth of a day every four weeks for sick days associated with allergy. That means if the average employee earns $15 per hour, companies are losing $1.4 million per 1,000 employees annually due to allergy alone. **(See box at right for the study's cost calculation formula.)**

Other allergy survey findings include the following:

- Depression costs employers $880,152 annually in lost productivity and affects roughly 9.1% of employees surveyed.
- Hypertension costs employers $520,884 annually in lost productivity and affects roughly 15.9% of employees surveyed.
- Other, nonallergy-related respiratory conditions cost employers $398,580 annually in lost productivity and affect 7.3% of employees surveyed.
- Asthma costs employers $275,808 annually in lost productivity and affects 5.2% of employees surveyed. **(See story on the asthma/allergy connection, p. 97.)**
- Diabetes costs employers $187,200 annually in lost productivity and affects 5% of employees surveyed.
- Heart disease costs employers $148,512 in lost productivity annually and affects 3.4% of employees surveyed.
- Hepatitis costs employers $36,504 annually in lost productivity and affects 1.3% of employees surveyed.
- High-risk pregnancy costs employers $46,644 in lost productivity annually and affects 2.3% of employees surveyed.
- Breast cancer costs employers $25,272 annually in lost productivity and affects 0.6% of employees surveyed.

[Editor's note: For additional information on the survey, contact the Employers Health Coalition, 1111 N. Westshore Blvd., Suite 608, Tampa, FL 33607-4702. Telephone: (813) 281-5665. Fax: (813) 286-2730.] ■

How Things Added Up

The Healthy People/Productive Community survey, conducted by two Tampa-based companies, the Employers Health Coalition and the Employers Purchasing Alliance, used a formula to calculate the business costs of diseases.

Here's the cost formula:
Annual costs = productive days lost for a four-week period × 13 weeks

Here's an example of how it works:
Annual costs due to allergy for an employer with 1,000 employees = 3.3 days lost to productivity × 279 employees affected by allergy × $120 per day salary × 13 four-week periods = $1,436,292 annual costs due to lost productivity

Treating asthma alone doesn't work

Experts say you must treat allergies, too

It doesn't surprise asthma specialists that the Healthy People / Productive Community survey conducted by two Tampa, FL-based firms found allergies cost employers more than any other medical condition. **(See p. 96 for survey details.)**

"There is a high prevalence of allergy in the United States," notes **James L. Sublett**, MD, national medical director of Vivra Asthma and Allergy in Plantation, FL. "There is also certainly a recognition by the National Heart, Lung and Blood Institute that allergy plays a significant role in persistent asthma. You have to look at asthma patients as allergy patients with different manifestations of disease state, including asthma. The focus of asthma management programs up until now has been on the train wrecks. The patients who end up in the emergency rooms or hospitals get lots of attention. But there's a lot of money being spent on allergy patients whose asthma has not been properly identified."

Asthma management programs that fail to assess patients for allergy may never succeed in controlling asthma symptoms, agrees **Michael C. Blaiss**, MD, an allergist and associate professor of pediatrics and medicine at the University of Tennessee in Memphis. "The majority of patients with asthma have an element of allergic rhinitis, much of which is not realized or treated. No allergy control means no asthma control in a majority of patients."

Most asthma management programs obtain a complete asthma profile and medical history from patients, he says. "But they should also include a complete history of the patient's allergy symptoms." Questions case managers and providers should ask their asthma patients include these:

- Does your nose run or itch when you are having asthma symptoms?
- Do you sneeze when you are having asthma symptoms?
- Do you have a family history of allergy?

When Blaiss discusses asthma with other providers, he always explains the "united airways" theory that there is such a strong connection between the upper airways of the nose and the lower airways of the lungs that to think of them as separate is not accurate.

Allergies should be assessed and treated because the most cost-effective, noninvasive treatment for asthma is avoidance of triggers, Blaiss adds. "Too many physicians just tell patients to give the family cat away without testing for allergy to cat dander. Many times the patient is reluctant to give away their pet, and without proof that the cat may be a cause of their asthma symptoms, it's an even harder sell. If you test for allergies, you can point to their arm and say, 'See that big reaction on your arm? That's what happens when you breathe cat dander.' By testing, you show patients the cause of their symptoms, and they buy into their treatment much better."

However, just as often, allergy testing doesn't provide a clear cause for a patient's asthma symptoms. "In the meantime, the patient's primary care physician has convinced him to give his pets away, and now you find that animal dander is not a trigger for that patient. You have one angry, dissatisfied patient," says Blaiss.

You also may have a noncompliant patient, notes Sublett. "The patient says, 'Hey, I got rid of two cats, and I'm still wheezing.' They end up failing to comply with their whole treatment plan due to their frustration."

To vaccinate or not . . .

Asthmatics who react strongly to allergy testing also may benefit from allergy vaccines, say Sublett and Blaiss. "There are different ranges of allergic reaction," Sublett says. "Individuals who have very strong allergies generally respond well to immunotherapy or allergy vaccines."

"For certain patients, vaccine therapy significantly decreases all allergy symptoms. It doesn't affect a 'cure,' but it can bring almost complete remission of asthma and allergy symptoms in responsive patients," Blaiss adds, "and allergy vaccines are easy for patients to understand. We vaccinate for tetanus, we vaccinate for hepatitis, why not allergies?"

Of course, allergy testing and allergy vaccines can come with a significant price tag, Sublett says. "If you take a short-term approach, immediate allergy testing and treatment is expensive. But if you look at total quality of life and long-term benefits, you put those costs into perspective. Studies like the Healthy People / Productive Community study illustrate the socioeconomic impact of allergies. We must begin to place more emphasis on the total patient who wants to be able to garden or play soccer or golf." ■

CDC releases data on traumatic brain injury

80,000 Americans permanently disabled annually

One American sustains a brain injury every 15 seconds. A staggering 80,000 of those, or nine people every hour, experience the onset of long-term disability following hospitalizations for traumatic brain injury (TBI), according to recently released statistics from the Centers for Disease Control and Prevention (CDC) in Atlanta.

This marks the first time national TBI incidence data have been analyzed for their impact on the health care system and society and released to the public, notes **Richard J. Waxweiler**, PhD. Waxweiler is director of the division of acute care, rehabilitation research and disability prevention at the National Center for Injury Prevention and Control at the CDC. Using data from a national database for 1995-96, the findings presented at a recent press conference in Atlanta include these:

- 1 million Americans are treated and released from hospital emergency departments for TBI each year.
- 230,000 people are hospitalized each year for TBI and survive.
- 50,000 people die each year from TBI.
- 5.3 million, or 2% of the total population of the United States, are living today with disability resulting from a previous hospitalization for TBI.
- The risk of TBI is highest for adolescents and young adults.
- The risk of TBI is twice as great for males as females.
- The leading causes of TBI are motor vehicle crashes, violence, and falls.
- Falls are the leading cause of TBI in adults over age 65.
- Transportation injuries are the leading cause of TBI in persons ages 5 to 64.

TBI patients and their families desperately need information about the potential long-term consequences of brain injury and where to turn for help, says **Allan Bergman**, chief executive officer of the Brain Injury Association in Alexandria, VA. "This is truly a silent epidemic. Few physicians and fewer Americans are aware of how many lives are touched by TBI," he says, "and physicians don't do a good job educating patients about TBI. Patients are released without adequate evaluation and follow up. They're given a head injury checklist, and most are never seen again. Years later, these individuals may end up with cognitive impairments, learning disabilities, or in the criminal justice system, and no one ever makes the connection between their current problems and their past TBI." **(See box, below.)**

Bergman says he hopes the new data will draw the attention of physicians and the community to the importance of accurate diagnosis and treatment. "How many coaches have watched a young athlete take a blow to the head, dusted him off, and sent him right back out on the field?"

The CDC plans to release a pamphlet, "Facts About Brain Injury" sometime soon, he says. In the meantime, the data and pamphlet are available on the CDC Web's site: www.cdc.gov.

(Editor's note: The next issue of Case Management Advisor *will discuss accessibility planning and the Brain Injury Trust, available in 14 states to offset clients' out-of-pocket expenses for assistive technology and home modifications. Also, look for details on building an accessibility team to develop a plan to meet your clients' needs.)* ■

Consequences of TBI

❑ **Possible cognitive consequences of TBI:**
• short-term memory loss • long-term memory loss • slowed ability to process information • trouble concentrating or paying attention • difficulty keeping up with a conversation • difficulty finding the correct word • spatial disorientation • organizational problems/impaired judgment • inability to do more than one thing at a time

❑ **Possible physical consequences of TBI:**
• seizures of all types • muscle spasticity • double vision, low vision, and blindness • loss of smell or taste • speech impairments such as slurred speech • headaches and migraines • fatigue, increased need for sleep • balance problems

❑ **Possible emotional consequences of TBI**
• lack of initiative • increased anxiety • depression and mood swings • impulsive behavior • denial of deficits • agitation • egocentric behaviors

Source: Brain Injury Association, 105 N. Alfred St., Alexandria, VA 22314. Telephone: (703) 236-6000 or (800) 444-6443. Web site: www.biauas.org.

Group offers in-home Alzheimer's test

A new at-home test for Alzheimer's disease hit the market in May. The test can be administered and scored in the patient's own home for less than $30, compared with costs ranging from $70 to $400 for other available Alzheimer's assessment tools.

The In-Home Alzheimer's Screening Test (I-HAST) concentrates on mental agility in a half dozen areas most commonly affected by Alzheimer's. It comes with instructions and all the necessary tools for administration and scoring.

The test is the product of a two-year effort by the Alzheimer's Research Foundation in Virginia Beach, VA. The six parts of the test resemble a word and pictures game. Each part takes less than 10 minutes to administer. Points are scored for missed answers, then totaled. Suggested indications and follow-up actions are provided for each scoring range.

A major evaluation of the test is planned for later this year to refine specificity and sensitivity. Individuals who purchase the test materials now may be included in the evaluation effort.

The test will be available in public libraries and bookstores. To register for the study or to purchase the test materials, call toll-free (877) 427-0220 or visit the foundation's Web site at www.alzheimer's-research.org. ▼

Elderly run risk for dangerous meds

Nearly one in 20 prescriptions given to the elderly during visits with physicians at hospital-affiliated outpatient departments involve a medication that experts agree generally should be avoided in the geriatric population, according to a recent study in the *American Journal of Health-System Pharmacy*.

Age-related changes to the structure and function of various organs make certain drugs dangerous or even life-threatening in the elderly.

Case Management Advisor™ (ISSN# 1053-5500), including **Resource Bank**™ and **Reports From the Field**™, is published monthly by American Health Consultants®, 3525 Piedmont Road, NE, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Case Management Advisor**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcpub.com). Hours of operation: 8:30 a.m. to 6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $299. Approximately 18 nursing contact hours, $349; Outside U.S.A., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $179 per year; 10 to 20 additional copies, $120 per year. Call for more details. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $50 each. (GST registration number R128870672.)

This continuing education offering is sponsored by American Health Consultants®, which is accredited as a provider (CEP10864) of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation.

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Drugs considered inappropriate include these:

- diazepam (Valium);
- propoxyphene (Darvon);
- dipyridamole (Persantine);
- amitriptyline (Elavil);
- cholordiazepoxide (Librium).

Researchers note that the odds of receiving a prescription for a potentially inappropriate medication are greater when elderly patients receive:

- care from a physician to whom they were referred;
- prescriptions for more than one medication;
- care in an outpatient department outside a metropolitan area;
- prescriptions for dipyridamole or an antispasmodic agent such as cyclobenzaprine, which has little benefit in the elderly.

[See: Aparasu RR, Sitzman SJ. Inappropriate prescribing for elderly outpatients. *Am J Health-Syst Pharm* 1999; 56:433-439.] ■

CMs must advocate for clients

An article in the April issue of *Case Management Advisor* included a statement attributed to **Mark Raderstorf**, CCM, CRC, LP, LFMT, president of Behavioral Management in Minneapolis. The statement read, "Raderstorf suggests supervisors share this advice with case managers."

The statement should have read as follows:

Raderstorf suggests *case managers* share the following advice with *supervisors*:

- 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.

Many employers have little understanding of mental disabilities or neurological impairments and the effect they may have on an individual's ability to process information and complete tasks, Raderstorf says. It's the case managers' role, after first receiving permission from the client, to educate supervisors and co-workers about any impairments the client may have and the affect those impairments may have on job performance. ■

CE objectives

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

1. Implement programs that support the continued education of their case managers.
2. Implement final preparation for year 2000 contingency plans.
3. List the top 10 diagnoses in terms of cost in a recent managed care study.
4. Locate a qualified accessibility contractor to meet their clients' home modification needs. ■