AMERICAN HEALTH CONSULTANTS®

# Case Management ADVISOR™

*Covering Case Management Across The Entire Care Continuum*

## INSIDE



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Professional development

# Has New Hampshire board drawn the first of many lines in the sand?

*Case managers in New Hampshire denied RN license renewal*

Several nurse case managers in New Hampshire were stunned recently when the New Hampshire State Board of Nursing denied their applications for renewal of their registered nurse (RN) licenses. The board says the move is a quality control issue designed to protect consumers in the state of New Hampshire.

Case management leaders warn that this policy, if it spreads, has far-reaching implications for all case managers, such as keeping nurses from acting as case managers.

"It came to our attention about a year ago that there were nurses in case management positions that did not require that the person holding the position be a registered nurse," says **Doris Nuttelman**, RN, EdD, executive director of the New Hampshire State Board of Nursing in Concord. "We have an active practice requirement. If an employer hires an RN as a case manager because the job requires the special skills and knowledge of a registered nurse, then the nurse case manager meets the practice requirement. If the employer also hires other professionals, such as social workers, to do the same case management position, then we feel that the job does not meet the active practice requirement for registered nurses in this state." She added that the board has challenged, and in some cases denied, license renewal for nurse case managers in payer, acute, and long-term care settings.

If the state board of nursing is simply practicing quality assurance, several industry leaders say, case managers should support the board in its efforts, but not before asking some hard questions. "We have to start some proactive discussions right now about the scope of professional practice as we move forward in new roles," says **Brenda-Jean Paradis**, RN, regional

manager in medical management for Blue Cross and Blue Shield of New Hampshire in Manchester and project manager to accreditation organizations. "To meet standards set by credentialing bodies such as the National Commission for Quality Assurance [in Washington, DC], we only hire RNs to do case management. Yet, we've had two RNs here whose license renewal applications are currently under review by the board of nursing."

### First, do no harm

"The health care system has required that health care professionals be more flexible and creative in their roles to meet new challenges in the delivery system," notes **Sandra L. Lowery**, BSN, CRRN, CCM, president of Consultants in Case Management Intervention in Francestown, NH, and president-elect of the Case Management Society of America (CMSA). "I'm concerned that this ruling has broad implications for nurses and other professionals who want to enter specialty areas. It could in essence prohibit nurses from taking case management positions, and my real concern is that consumers will be left without a valuable service."

If a nurse case manager can no longer be relicensed, that nurse is no longer of value to a health care organization, agrees **Kathleen Moreo**, RN, BSN, BPSHSA, CDMS, ABDA, RN,Cm, owner and president of PRIME, a case management consulting and education firm in Miramar, FL, and president of CMSA. "Organizations will turn to less-appropriately trained and credentialed individuals, and the consumer, the very person the board of nursing is trying to protect, will be harmed."

And it's not just nurse case managers who are affected when their professional roles are challenged, but all case managers no matter what their discipline. "As case managers, we must work in support of each other regardless of our backgrounds. We spend so much time as professionals developing the skills we need to function as case managers; when one of us is challenged, we must all speak out," says **Karen Coish Mackey**, BSW, MBA, case manager with Regional Partners in Occupational Health, an occupational health practice in Manchester, NH, and president of the New England Chapter of CMSA. "In the past, I worked as director of an acute rehabilitation case management department which employed both nurses and social workers as case managers. I believe at times the skills of the different disciplines compliment each other. I also believe that there are times, and that there are cases, which require the strengths of either a nurse or a social worker."

CMSA recognizes and supports the right of health care professionals from a variety of disciplines to perform case management. "We [CMSA] believe that case management is an advanced practice based on licensure and certification that can be appropriately done by a variety of health care professionals within the scope of their education, experience, and professional licensure. That's what it says in the CMSA Standards of Practice." **(For more on the standards of practice, see p. 152.)**

If you practice outside New Hampshire, don't be lulled into a sense of false security. The New Hampshire State Board of Nursing has issued a wake-up call, and this is no time to be passive, caution industry leaders.

"I don't believe for a moment that this issue, and others like it that negatively impact case managers, will end in New Hampshire," says Moreo. "This situation is going to have a ripple effect. This is about health care economics. We are all going to be asked to be more accountable for who we are and what we do. It's not necessarily a bad thing, but one we must respond to and govern appropriately."

### So, what is 'nursing'?

The American Nurses' Credentialing Center (ANCC) in Washington, DC, is grappling with similar issues for nurses who hold its nursing case management certification (RN,Cm), which became available in 1997, as well as certifications for other nursing specialties that don't clearly involve direct patient care. "Many of our recertification requirements have wording that refers to 'direct patient care.' Depending on what type of


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case management you practice, as a nurse case manager you may not even see your patient," notes **Mary Smolenski**, EdD, RN-CS, director of certification services for the ANCC.

ANCC has had inquiries from nurses concerned they may not be recertified because of the requirement that certified nurses perform "direct patient care," she notes. "We get a great many calls on this issue. Nurses are questioning themselves and the jobs they've taken or are considering accepting. They wonder, 'If I take this job, will it count towards recertification?' Over the past two years, this has become a huge issue. There are more and more jobs for nurses in the health care industry that don't involve direct patient care, and case management certainly falls into that category."

ANCC's 11-member commission is reviewing its definition of "direct patient care," she adds. "One argument that has been discussed is that if a nursing intervention impacts a patient outcome, it could be considered direct patient care even if the nurse did not interface with the patient face to face," she says. "Under that definition, I think nurse case managers could argue that they meet the requirement."

### *One title, many disciplines*

Of course, case management always has been a multidisciplinary field, and nurses are not alone in struggling to define new professional opportunities. The National Association of Social Workers (NASW) in Washington, DC, is the latest group to attempt to establish a quality control process for case managers. Its new specialty certification for social work case managers will be available in late fall. **(For a look at certification opportunities for case managers, see *Case Management Advisor,* January 1997, pp. 1-6.)**

"The title 'case manager' is used by many different disciplines. Each discipline approaches case management differently. We felt this was an appropriate time to set criteria for social work case managers," says **Susan Merrick**, ACSW, LCSW, senior staff associate with NASW.

The important thing for case managers to remember is that it's better to be proactive than wait until it's time to renew their professional licenses or certifications to review the requirements and take corrective action, if necessary. "This is a wonderful wake-up call for case managers and their employers to review and update their case management job descriptions and

## So, what are you anyway?

*Speak now or forever hold your peace!*

The issues raised by the current situation in New Hampshire reach to the very core of your professional identity. Across the country, similar questions are being raised by licensing boards, credentialing commissions, and legislators.

Case manager beware: Your days of comfortably wearing two hats may be drawing to a close. It just might be time for case managers to gaze in the mirror and decide who they are and where they are headed as case management professionals.

Case managers should ask themselves these questions:

- Are you a nurse, social worker, or therapist who does case management, or are you first and foremost a case manager?
- Do you stand united with your case management peers from allied health care professions to maintain the traditional stance that case management is an advanced practice of a health care profession?
- Do case managers need to begin the process of establishing a separate and distinct case management profession?
- Do you erect barriers to practice that shut some health care professionals out of this growing field?

In the January 1998 issue of *Case Management Advisor*, we printed the results of a reader opinion poll on the current status of case management as an evolving profession. We asked our readers to tell us whether they thought case management was a profession, a specialty practice of a health care profession, or a role or task of a health care professional. Responses included:

- 65% said case management is a specialty practice of a health care profession.
- 26% said case management is a profession.
- 9% said case management is a role or task of a health care professional.

*(The editors of* CMA *invite you to respond to the current environment. If you would like to share your case management philosophy, information about rulings or legislation impacting case managers in your state, or simply express your opinion on the qualifications for a case management professional, please e-mail lee.landenberger@medec.com. Selected responses will appear in future issues of* CMA *as we continue to monitor issues that affect your professional practice.)* ■

consider education and outreach efforts," says Lowery.

Here are five actions industry leaders interviewed by *CMA* urge case managers to take to protect their professional status:

1. **Review licensing and credentialing requirements.** Ask your state professional board for a copy of relicensing requirements. If you are unclear about any of the requirements or whether you meet a particular requirement, ask for a clarification before it's time to renew your license. Take corrective actions, if necessary.

2. **Ask for a list of board members.** Ask to see a list of the board members, and if you feel that case management is not well-represented, work to make changes in the composition of the board.

3. **Write an accurate case management job description.** Ask your employer for a copy of your job description. If it fails to accurately reflect your duties and responsibilities, make suggestions for revising it. **(See story at right for suggestions on writing case management job descriptions.)**

4. **Keep your state and national professional associations informed about developments in your area that impact case managers.** One person can make a difference. Your professional associations have a strong voice and will use it to help resolve professional conflicts facing case managers. **(See p. 153 for examples of how one national association helped its members to resolve a professional conflict.)**

5. **Educate consumers and policy-makers.** If you feel that policy-makers or consumers are misinformed about the role and function of case managers, provide them with educational materials, such as case management standards of practice and codes of ethics.

### *An opportunity to learn*

"This situation in New Hampshire is an opportunity for us as a health management company to educate our members and our state about case management," says Blue Cross and Blue Shield of New Hampshire's Paradis. "Managed care has been portrayed as the bogey man, and case managers have been along for the ride. It's time we change that perception and educate people about the patient advocacy case managers provide."

**(See *CMA*, September 1999, pp. 137-138, to learn about one managed care company's big investment in consumer re-education.)**

*[Editor's note: For more information or an application for the Washington, DC-based National Association of Social Workers' new specialty certification for social work case managers, call (800) 638-8799, ext. 447, or visit the association's Web site at www.socialworkers.org.]* ■

## Leaders urge following CMSA standards

*A unified front is needed, industry leaders say*

The best definition of the roles and functions of a case manager to date are the 1995 *CMSA Standards of Practice for Case Management,* written and published by the Case Management Society of America (CMSA) in Little Rock, AR, according to many case management industry leaders interviewed by *Case Management Advisor.*

"The standards are our best defense. They should be every case manager's bible. If we all follow the standards, we present a unified front no matter where or how we practice case management," says **Sandra G. Colahan**, RN, CCM, a nurse case manager with Aetna in Branford, CT, and the president of the Connecticut state chapter of CMSA.

"I get very concerned when professionals call themselves case managers but fail to follow the standards of practice," she says. (The CMSA Standards of Practice provide a framework for writing a concise job description for case managers. In many cases, an accurate job description may be the most vital document a case manager presents when seeking relicensure or recertification. **See cover story for more information.**)

Case managers should review their job descriptions and, at a minimum, assure that both their job descriptions and their actual practice adhere to the core functions of a case manager outlined in the CMSA standards, agrees **Sandra L. Lowery**, BSN, CRRN, CCM, president of Consultants in Case Management Intervention in Francestown, NH, and president-elect of CMSA. "I believe that this will allow case managers to respond to challenges, such as those raised by the New Hampshire State Board of Nursing."

The standards define the case management role and outline these four case management functions:

• **Assessor.** The standards require a case manager to gather all relevant data and information regarding a case by interviewing the client, the family, and performing an evaluation of the entire situation. Case managers are also required to objectively evaluate all current treatment information to identify barriers, clarify realistic goals and objectives, and seek potential alternatives.

• **Planner.** The standards require case managers to work with the client and family to develop a treatment plan that enhances client outcome and reduces the payer's liability. Case managers also are required to initiate, implement, and monitor treatment progress.

• **Facilitator.** The standards require case managers to promote communication between all team members, the client and family, and all concerned parties.

• **Advocate.** The standards require case managers to incorporate the client's individual needs and goals. Case managers also are required to educate and empower the client.

*[Editor's note: Every CMSA member receives one free copy of the 24-page document. Additional copies are available to members for $10. Nonmembers may buy copies for $12. Bulk rates are available. For more details, contact CMSA, 8201 Cantrell Road, Suite 230, Little Rock, AR 72227-2448. Telephone: (501) 225-2229. Fax: (501) 221-9068. Web site: www.cmsa.org. E-mail: cmsa@cmsa.org.]* ■

# CMSA responds to NH Board of Nursing

*Professional associations advocate for members*

The New England chapter of the Little Rock-based Case Management Society of America contacted the national office in mid-August to ask for assistance in addressing a decision by the New Hampshire State Board of Nursing in Concord to deny renewal of the registered nurse licenses of several nurses working as case managers in that state. The response was swift: A letter went out within days to the board expressing concern and asking for clarification about its recent decisions. **(See letter, p. 154.)**

"The local chapters of CMSA and other profession organizations provide wonderful leadership. When case managers have concerns, they should turn to their local chapters for help," explains **Danielle Marshall**, director of membership / chapter service and special interest groups for the national office of CMSA. "And when local chapters want to add the authority of the national association in order to reach resolution of professional issues, they have access to a direct link to the national office."

## *CT takes a stand*

CMSA has intervened effectively in several states at the request of local chapters concerned about legislation and other rulings that affect case management practice. "The state workers' comp commission sent out a memo proposing changes to the workers' comp laws that would have been in direct violation of the CMSA Standards of Practice and Code of Ethics. I was out of town when the memo came out. When I returned, I was inundated with phone calls from local members who were angry and concerned. I called national for advice on how to address this issue. I felt I didn't have the clout myself to talk to the workers' comp commissioner directly, but that the national office did," says **Sandra G. Colahan**, RN, CCM, a nurse case manager with Aetna in Branford, CT, and president of the Connecticut chapter of CMSA.

With assistance and support from the national office, the Connecticut chapter took the following steps:

• Sent a written response to the workers' comp commissioner who issued the memo asking him to clarify the rationale behind his proposal and explaining that the changes would violate the CMSA Standards of Practice.

• Asked local members who had called to voice their concerns also to write letters to the commissioner.

• Invited the head of the Connecticut workers' comp commission to attend the state chapter conference to engage in a dialogue with case managers.

"She [Colahan] approached the problem in a very professional, nonconfrontational way. She alerted the workers' comp board that its proposal had potential legal and ethical implications for case managers. She encouraged the workers' comp board to look at the standards of practice. Connecticut later ruled in a way that was more

acceptable to everyone," notes Marshall.

What happened between the Connecticut chapter and national was a wonderful example of a state/national partnership, she adds. "I want local CMSA members to know that I am here to serve them in whatever way I can."

"When something slaps you in the face, you must be proactive," adds **Kathleen Moreo**, RN, BSN, BPSHSA, CDMS, ABDA, RN,Cm, owner and president of PRIME, a case management consulting and education firm in Miramar, FL, and president of CMSA. "Education is the key. We are a rapidly evolving, multidisciplinary practice. I'm sure other practices have faced similar barriers in their formative years. As case managers, we work to validate our worth to payers on a consistent basis. Now we must do the same with policy-makers." ■

# Letter asserts value of case management

*(Editor's note: Here is the text of the letter from Jeannie Boling, MSN, CRRN, CDMS, CCM, executive director of CMSA, on Aug. 24, 1999, to Doris Nuttelman, RN, EdD, executive director of the New Hampshire State Board of Nursing in Concord. At press time, CMSA had not received a response from the New Hampshire State Board of Nursing. We will continue to monitor the situation, as well as issues in other states that affect the practice of case management.)*

**Dear Dr. Nuttelman:**

By way of introduction, the Case Management Society of America (CMSA), founded in 1990, is an international multidisciplinary professional organization. As such, it embraces individuals performing case management roles within the scopes of various disciplines including nurses, social workers, vocational counselors, occupational and physical therapists, and physicians.

This letter is in response to the recent concerns from our case manager nurses that their New Hampshire nursing licenses would not be renewed if they were practicing as case managers. Our understanding of the issue is that the Board of Nursing does not support nurses who were practicing their unique skill if another could perform the job. Please advise if this is the stated position of the Board on this issue.

CMSA wishes to submit the following information from our perspective as a national health care association to assist as you further explore this issue. As CMSA has found, case management requires a specific understanding of how each professional (whether RN, SW or other) may function in his or her position.

In 1995, CMSA developed The Standards of Practice for Case Management, which have been widely embraced in the health care marketplace. The major certifications and accreditations for case managers and case management departments recognize these standards as a primary source in defining the field. The American Nurses Association has developed similar standards for nurse case managers.

The CMSA Standards of Practice recognize case management as an advanced practice, one that is based on the licensure of each professional as well as more advanced skills gained through education and/or experience. Further, it presumes the professional will function within the scope of his or her professional discipline, education and experience, and personal expertise.

Therefore, it is the position of CMSA that nurses or other discipline professionals who would practice in a position in which other professionals might also function, should be of no consequence. While the nurse functions within her expertise in "assessment," for example, that does not mean that the social worker or vocational counselor will function in the same manner nor that the outcome would be the same. The social worker may focus primarily on the social needs of the individual; the vocational counselor may focus primarily on the vocational needs of the individual. Nevertheless, the job description may require "assessment" and each professional may function satisfactorily in that role.

Is the New Hampshire Board of Nursing focusing solely on the traditional clinical application of basic nursing rather than the community and health system application? If so, it would appear to be limiting nurses from applying their unique skills to other positions, a critical need for nursing as well as for consumers in the current healthcare atmosphere. How would the RN functioning in a case management position differ from an RN functioning as a supervisor or educator? Not one of the nurses in those roles would have a hands-on clinical role, a role which more fully employs the traditional unique clinical skills of the nurse.

*(Continued on page 159)*

# Reports From the Field™

**Medicaid/Medicare issues**

## Managed Medicaid programs successful in rural areas

Two recently released studies suggest that managed Medicaid programs significantly improve health care for the rural poor.

The first study assessed the number of 2-year-olds in a national sample of 8,100 who were up-to-date on their immunizations; the count was based on the 1988 National Maternal and Infant Health Survey and its 1991 Longitudinal Follow-up. Researchers found that 33% of poor children and 44% of other children had up-to-date immunizations. Poor children with public sources of routine pediatric care were more likely to have their full immunization series than poor children with private sources of routine care.

Researchers also found that more extensive Medicaid coverage for the poor was associated with a greater likelihood of having full immunization series among poor children; however, they noted that the effects of expanded Medicaid coverage were limited.

For roughly 60% of poor children in the study covered by Medicaid, additional Medicaid coverage did not increase the likelihood of more complete immunization.

The second study focused on the estimated 703,000 Medicaid beneficiaries in rural areas in capitated managed care plans and the even larger number participating in primary care case management programs (PCCM). Researchers did a case study of 10 states that have implemented Medicaid managed care programs to determine the impact of those programs on access to care.

In 1997, researchers conducted telephone interviews with 130 key officials in the 10 states, such as state agency representatives, rural care providers, representatives of managed care organizations, and consumer advocates. They found that implementing PCCM and managed care programs was possible even in remote rural areas.

### *Steps to success*

They noted these steps that appear essential for success:

- States should allow greater time and effort to implement programs in rural areas.
- States should allow enough time to build provider networks.
- States should provide adequate time to build support for the program through interaction with local representatives.
- States should design geographic program boundaries that recognize local use patterns.

Researchers also noted that building provider networks in rural areas requires more time and effort due to rural providers' inexperience with managed care and communication barriers.

[See: Mayer ML, Clark SJ, Konrad TR, et al. The role of state policies and programs in buffering the effects of poverty on children's immunization receipt. *Am J Public Health* 1999; 89:164-170. See also: Felt-Lisk S, Silberman P, Hoag S, Slifkin R. Medicaid managed care in rural areas: A ten-state follow-up study. *Health Aff* 1999; 18:238-245.] ▼

## Families of disabled neglect their own care

A recent study found that among poor families, the effects of having a disabled family member were more likely to reduce medical care use and expenditures among nondisabled family members.

The study found that adults in poor families with a disabled family member were 16% less likely to visit a physician than adults in high-income families with a disabled family member. Researchers suggest that public programs recognize the potential rationing effect that occurs when income is limited and one family member uses the bulk of health care resources.

[See: Altman BM, Cooper PF, Cunningham PJ. The case of disability in the family: Impact on health care utilization and expenditures for nondisabled members. *Milbank Quarterly* 1999; 77:39-75.] ■

### Cardiology

## Race, sex influence cardiac care decisions, study finds

A recent study found that a patient's race and sex may influence physicians' recommendations for cardiac catheterization.

The study found blacks and women with chest pain had relative odds of referral for cardiac catheterization that were 60% of the odds for whites and men, with the greatest disparity in testing for black women. Black women in the study fared the worst, with relative odds for catheterization that were 40% of those for white men.

### *How it was done*

The carefully controlled study used computer multimedia technology to address the study question. Actors posing as patients, including two black men, two black women, two white men, and two white women described their chest pain using the same scripts reporting identical clinical symptoms. The actors wore identical gowns, used similar hand gestures, and reported having the same insurance coverage and occupation.

Researchers asked 720 primary care physicians at annual meetings of professional societies to review the patient's medical data, assess his or her diagnosis, and recommend further diagnostic tests. Physicians were told that they were participating in a study of clinical decision making.

[See: Schulman KA, Berlin JA, Harless W, et al. The effect of race and sex on physician's recommendations for cardiac catheterization. *N Engl J Med* 1999; 340:618-626.] ▼

## Subsequent strokes result in higher costs, poorer outcomes

Patients who suffer a second or third stroke have poorer outcomes and higher health care costs than patients suffering a first stroke. In addition, fewer patients survive a second or third stroke and are more disabled if they do survive.

Researchers used administrative claims from a random 20% sample of nearly 50,000 Medicare patients admitted to U.S. hospitals with a primary diagnosis of cerebral infarction in 1991. They reviewed hospitalization data from the previous four years to classify patients as having either a first or recurrent stroke. Patients' survival and direct medical costs were followed for 24 months after stroke. Researchers found:

- 57% of first-stroke survivors were alive 24 months following stroke, compared with 48% of those suffering a recurrent stroke.
- Medical costs were similar for the initial hospital stay and in the first three months after stroke for first-stroke and recurrent-stroke patients.
- Medical costs for months four to 24 following stroke were roughly $375 more per month for recurrent stroke patients than for first-stroke patients.

Researchers note that most of the monthly medical costs were attributable to nursing home use and acute hospitalization costs.

[See: Samsa GP, Bian J, Matchar DB. Epidemiology of recurrent cerebral infarction: A Medicare claims-based comparison of first and recurrent strokes on two-year survival and cost. *Stroke* 1999; 30:338-349.] ■

## Readmissions don't mean bad care for Medicare patients

A recent study of Medicare patients in four states found that patient readmissions are not necessarily related to poor quality care during the first visit.

Researchers reviewed hospital records on readmission diagnoses and intervening time periods to identify readmissions that indicated potentially inadequate care during initial hospitalization. The study group consisted of 1,758 Medicare patients hospitalized in New York, Pennsylvania, Massachusetts, and Illinois during 1991 and 1992 with pneumonia or congestive heart failure. In simulations, readmission did not vary significantly between average and low quality hospitals.

[See: Weissman JS, Ayanian JZ, Chasen-Taber S, et al. Hospital readmission and quality of care. *Medical Care* 1999; 37:490-501.] ▼

## Studies show many lab tests are conducted unnecessarily

Two recently released studies indicate that some costly lab tests performed in the hospital setting may be unnecessary.

In the first study, researchers found that 84% of inpatient digoxin level tests had no appropriate indication. Of those 84%:

- 76% were serial tests drawn less than 10 days apart;
- 9.5% were performed on patients not receiving digoxin;
- 8.5% were done after initiation of digoxin therapy but before a pharmacological steady state had been achieved;
- 3% were done to follow levels in the toxic range that were measured before the level could be expected to decrease to the therapeutic range.

In addition, 48% of the digoxin levels measured in outpatients had no appropriate indication. Of the inappropriate outpatients digoxin levels:

- 76% were due to early routine monitoring;
- 13 were performed on high-risk patients;
- 2% were performed on patients who had worsening congestive heart failure or atrial fibrillation;
- 2% were performed after changing the digoxin regimen but before a steady state had been reached;
- 8% were due to other causes.

The second study found that a total of 939 apparently redundant tests were ordered over a four-month period at one hospital. Physicians of the 5,700 patients in the study who ordered tests via computer terminal received computerized reminders if a test was redundant, meaning it had been performed previously or was pending. Physicians of the 5,886 patients in the control group received no computerized reminders.

Researchers found that 69% of tests were canceled by study group physicians when a reminder was sent out. Physicians ordered tests despite computerized reminders in 137 instances. Of those 137, 41% appeared to be justified based on review of patient charts.

[See: Casas F, Tanasijevic MJ, Ma'luf N, et al. Evaluating the appropriateness of digoxin level monitoring. *Arch Intern Med* 1999; 1,159:363-368. See also: Bates DW, Kuperman GJ, Rittenberg E, et al. A randomized trial of a computer-based intervention to reduce utilization of redundant laboratory tests. *Am J Med* 1999; 106:144-150.] ▼

## Use of hospitalists has pros and cons

The use of hospitalists is expanding across the country as a new model for inpatient care. A recent supplement in the *Annals of Internal Medicine* profiled this growing movement in a recent 10-article supplement. Among listed advantages to the use of hospitalists over primary care physicians are:

- increased availability to hospitalized patients;
- greater hospital experience and expertise;
- increased commitment to hospital quality improvement.

Potential disadvantages for the use of hospitalists rather than primary care physicians are:

- loss of information caused by the outpatient-hospital discontinuity;

• dissatisfaction of patients who are handed off to a new physician at the time of hospital admission.

The supplement includes the first national survey of hospitalists. The survey found that 89% of hospitalists are internists, with 51% being general internists and 38% medical specialists.

The survey also found:

• Most hospitalists limit their practice to the inpatient environment, but 37% continue a limited outpatient primary or consultative practice.

• About one-third (35%) of hospitalists are employed by a medical group, compared with 23% employed by a hospital and 14% by a managed care organization.

• Most hospitalists report job satisfaction, with 84% of generalists and 73% of specialists expecting to still be a hospitalist in three years.

[See: The hospitalist movement in the United States. *Ann Intern Med* 1999; 130(4):Suppl.] ■

**Disease management**

## Drug controls Parkinson's, lowers dyskinesia risk

A recent study presented at the 13th International Congress on Parkinson's disease in Vancouver shows that ropinirole hydrochloride successfully manages Parkinson's disease and significantly lowers the risk of developing dyskinesia, or involuntary body movements that often are associated with other Parkinson's therapies.

Researchers randomized a sample of 268 Parkinson's patients to receive with ropinirole hydrochloride or levodopa and evaluated them over a five-year period. The double-blind, parallel-group study evaluated the incidence of dyskinesia. Patients in both groups whose symptoms were not improved were given supplemental levodopa.

Of those enrolled, 130 patients completed the five-year study with 85 in the ropinirole hydrochloride group and 45 in the levodopa group. Findings include:

• 64% of patients in the levodopa group and 34% of patients in the ropinirole hydrochloride group completed the five-year study without supplemental levodopa.

• The incidence of dyskinesia was 5% in the ropinirole hydrochloride group and 36% in the levodopa group.

• Of patients receiving supplemental levodopa, 20% of the ropinirole hydrochloride group with supplemental levodopa developed dyskinesia, compared with 46% of levodopa patients receiving supplemental levodopa. ▼

## Asthma patients prefer emergency room to hospital

Patients admitted to the emergency room (ER) suffering from an acute asthma episode are more satisfied with their care if they remain for 12 hours in an emergency room-based observation unit than if they are admitted to the hospital, a study says.

Researchers studied 163 asthma patients admitted to the ER over a 30-month period who met the criteria for hospital admission after three hours of ER asthma therapy. They randomly selected 81 patients to receive care in an ER-based observation unit and 82 patients to routine hospital admission.

Patients in the observation unit group scored higher after diagnosis and treatment than those in the inpatient group on seven care satisfaction measures.

### *The dividing line*

The observation unit group scored significantly higher than the inpatient group on these four measures:

• received services desired;
• would recommend the service to others;
• were satisfied with service;
• were satisfied overall with care.

In addition, the observation unit group reported fewer total problems with care and fewer problems with communication, emotional support, physical comfort, and special needs than inpatients.

[See: Rydman RJ, Roberts RR, Albrecht GL, et al. Patient satisfaction with an emergency department asthma observation unit. *Acad Emerg Med* 1999; 6:178-183.] ■

(Continued from page 154)

A physician or other licensed professional may fill the roles of supervisor or educator as well. Thus, to say that a case manager RN is not using the unique knowledge of an RN if the role may be performed by another would appear to be faulty logic. Not only would this position appear to be hindering individual nurses from creativity in practice, it would appear to further damage nurses' capability to gain certification and to demonstrate competency in various specialties including case management. Further, the impact of this position on employers of nurses in the new health systems is dramatic, potentially affecting hiring practices, companies' ability to meet accreditation criteria based on RNs performing in the roles in question, and eventually impacting the economic viability of payer and managed care entities. Most importantly, the key role the nurse case manager fills as patient advocate is in danger of being filled by a less qualified individual. Thus, the consumer is ultimately impacted by a decrease in service and quality.

CMSA sees this dilemma as an opportunity to offer information to health policy experts and legislators about the role of the nurse case manager. With this in mind, enclosed please find a copy of the CMSA Standards of Practice and a copy of Case Management At the Point of HealthCare's Future. I am certain the Board does not intend harm to nursing or to the patients nursing serves. Please consider the foregoing information. If I can be of further assistance, I will be glad to be available as a resource.

**Sincerely,**
**Jeannie Boling, MSN, CRRN, CDMS, CCM**

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**Workers' comp/disability management/ behavioral health**

# Recognizing and treating PTSD speeds recovery

*Here are tips on managing post traumatic stress*

Case managers understand physical trauma. It's very easily identified and measured. Psychological trauma is often harder to recognize, yet left untreated, post-traumatic stress disorder (PTSD) may prevent your client from returning to the workplace.

"As case managers, as you work with people who have injuries, you must consider the role of trauma. Talking about psychological trauma is difficult because there is a subjective quality to it," says **John H. Hung**, PhD, LP, senior partner of Health Psychology Consultants in Edina, MN, and clinical assistant professor of family practice and community health at the University of Minnesota Medical School.

Any time a person experiences an event outside normal everyday experience, such as violence, illness, or injury — something unusual for that person — there is a response, notes Hung. Common responses to trauma, such as a work-related injury, include:

- shock;
- denial;
- disorganization;
- depression;
- guilt;
- anxiety;
- aggression;
- resolution and acceptance;
- reintegration.

"We know that following any type of trauma, those are universal human reactions. We need to be able to express our emotions freely to recover from a traumatic event. We need to cry, feel anger, feel sadness. We need to discuss what happened," says Hung.

However, not every client feels these needs immediately. "Your client may not need to talk about the accident until six weeks after the event. Others will start talking while they are still in the hospital," he explains.

But there is a difference between the normal human need to express anger or sadness over a traumatic event and PTSD. Not every client who experiences a traumatic event develops PTSD, and even among those who do, many recover without any treatment, notes Hung. "About 60% of clients with PTSD recover on their own. Of the remaining 40% many will have some symptoms but still function normally. It's just a small percentage, perhaps as few as 10%, who can't cope or resolve their symptoms without help," he explains.

Case managers should expect most clients to have decreased stress symptoms six to eight

weeks after a traumatic event. "But if you are looking at a client who has been off the job for six months post injury and still refuses to return to the workplace, assess the possibility of PTSD."

PTSD is a psychiatric diagnosis that requires that clients meet specific criteria, says Hung. Those criteria include:

• **Exposure to a traumatic event.** "Without a traumatic event, there is no PTSD. If your client is fearful of a variety of things, you may be dealing with an anxiety disorder, but you aren't dealing with PTSD," says Hung. "A traumatic event is one which involves a threat to one's life or physical safety or the witnessing of a horrifying event out of the ordinary human experience."

• **Re-experiencing of a traumatic event.** To meet this criterion, the re-experience must be intrusive. "If six months after I lose my hand due to injury, I walk around and suddenly, not because some sight triggers a memory, I think about my hand — I remember vividly how it was caught in the die machine — I find that very upsetting because it is not under my control," says Hung.

Nightmares also may cause your client to re-experience the traumatic event. "Maybe I dreamt I was working on the die machine again and my hand was caught and I couldn't get it out. Or I was being chased by someone and I couldn't escape because I didn't have my hand to open the door."

Sometimes, clients with PTSD have flashbacks. They don't simply remember the event, they actually feel as if it was happening again. "I've seen Vietnam vets sitting in a room talking, and they will hear something that sounds similar to a helicopter and suddenly dive under a table."

• **Avoidance or numbing phenomena.** "This doesn't mean simply avoiding the activity that lead to the injury. I consider that fairly normal. This means an avoidance of activity: withdrawal."

• **Symptoms of increased arousal.** Some clients exhibit irritability or outbursts of anger, notes Hung. "Clients may also have an exaggerated startle response — you come up behind them and they jump and run out of the room."

• **Duration of greater than one month.**

• **Distress or impairment in function.**

There are several key considerations for case managers working with PTSD patients, Hung notes. Those include:

• **Timing of interventions.** "I generally recommend that a case manager become involved with a PTSD case as quickly as possible. That doesn't necessarily mean you jump in full blast, but establish contact. Let the client know you are available and express your concerns with the treating physician," recommends Hung.

• **Debriefing.** "This is very important from the employers' standpoint. The case manager or the psychiatrist should put the employer, the employee, and the co-workers through a debriefing after a traumatic event in order to ease return to work down the road."

• **Assessment of risk factors and complicating factors.** "The greater the exposure, the greater the risk for PTSD. If I suffered an injury that took me off the job and then dragged out my benefits checks and I lost my house, then my wife left me after I lost the house, the greater the support [I would need]. Each exposure — the injury, the delayed payments, the loss of home, and the loss of the spouse — is an additional displacement.

"Review the details of the injury. If instead of losing consciousness when my hand got caught in the die machine and waking up in the hospital without my hand, I saw what happened, my exposure is much greater. My hand was caught in the machine for 20 minutes and I had to watch. I was afraid to move. That's much worse than if your client lost consciousness and has no real memory of the trauma."

## *What's your coping style?*

It's also important to understand your client's coping mechanisms. "If my personality style has always been to deny or minimize negative situations, that is likely to continue. If my coping behavior when I'm under stress is not to answer the phone but to escape by reading or watching television, I may take longer to recover from trauma," notes Hung. "If my coping style is to call my friends and tell them I need some support, then it will help me a great deal and I'm likely to recover on my own."

He suggests case managers ask questions that help reveal their clients' coping styles. "Ask family and friends, as well, how your client has handled experiences in the past."

Hung also recommends that case managers assess the "recovery environment." Issues to consider include:

— **Social supports.** What family is available? How is the family reacting to the trauma? Are the client's friends accepting the trauma, or are they treating the client differently?

— **Demographic profile.** Children generally

recover more quickly from trauma than adults, notes Hung. In addition, better-educated clients generally recover more quickly.

— **Cultural characteristics.** "If your client comes from a culture, like many Asian cultures, that places heavy emphasis on the appearance of the face, and your client has an injury which leaves a facial scar, your client's reaction to the injury may be more dramatic than you would normally expect from such an injury," Hung says.

• **Referral for professional treatment.** "If your client is more than six weeks past a traumatic event, physically stable, but is still not sleeping and has started to abuse alcohol, that's enough to refer them for psychiatric treatment," he says.

• **Pharmacological management.** Antidepressants and anti-anxiety drugs may be effective in treating PTSD, says Hung.

• **Returning to the environment where the trauma occurred.** "Returning to the workplace is really one of the last tasks you must help your client through," says Hung. "You must be fairly confident that your client is recovered fully, or simply revisiting the machine that caused the injury may set your client back six months."

As a case manager, it may be your job to rule out PTSD rather than help identify it, Hung says. He was called in to evaluate a roofer who had fallen off a roof and suffered massive injuries. Although the man was fully recovered physically, he firmly refused to return to the job. Hung's evaluation revealed that the man suffered from no flashbacks, startle response, or sleep disturbances.

"The man finally admitted that he was simply afraid to go back up on a roof. He told me he had always known he had a dangerous job even before his accident. He simply felt if he went back up on a roof again, he would be injured again. While I empathize, that's not a psychiatric condition; I consider that quite sane. Unfortunately, there's no good way to address that in workers' comp."

In that case, Hung suggests the case manager intervene with the employer and attempt to find the employee another job within the company. ■

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Long-term care/geriatrics

# Is your elderly client suffering from dementia?

*Make sure it's not depression*

Many behaviors that get the elderly in trouble are not Alzheimer's-related dementia but actually signs of depression that, if properly managed, not only correct behavioral problems but greatly improve the quality of life of many nursing home residents.

"The behaviors which often lead to nursing home referrals, such as verbal abusiveness and combativeness, are not behavioral problems associated with adult dementia are more often caused by depression," says **Daniel Cowley**, PsyD, a licensed psychologist with a mobile practice who consults on geriatric cases in North Carolina and South Carolina. "There are some commonalities in children and the elderly in terms of depression. A depressed child is often diagnosed as hyperactive: the child strikes out, acts aggressive or angry, and people think the child is acting out. The truth is that the hyperactive child often is a depressed child treated with the wrong class of drugs, and the same thing happens in the elderly."

Roughly 5% to 10% of nursing home residents are treated for depression, when the actual number of depressed nursing home residents is probably closer to 40%, says Cowley.

Unfortunately, dementia and depression often go hand in hand, adds **Istvan Boksay**, MD, PhD, director of the William and Sylvia Silberstein Aging and Dementia Research Center at the New York University Medical Center and chief of psychiatry and clinical associate professor in the department of psychiatry.

"It's not uncommon for a patient to have a very mild dementia that's not even diagnosable at this point. When these patients become depressed, their cognitive function worsens. Suddenly, you see a patient experience a dramatic decline which makes the dementia look much worse than it is. And, of course, many patients told they have Alzheimer's react with depression. You tell some one that their mind is not functioning as it used to, it's not surprising that it triggers a depression."

If the depression is treated early and aggressively, then the dementia improves and you see a return to baseline, says Boksay. **(See tables,**

**inserted in this issue, for California Workgroup on Guidelines for Alzheimer's Management recommendations for treatment of dementia and depression. For more on the Guidelines for Alzheimer's Management, see *Case Management Advisor,* August 1999, pp. 124-125.)**

"If you treat the depression appropriately, you can reverse the decline. Once the depression is completely resolved, you must reevaluate the dementia and treat it, if necessary."

To make it even more difficult to recognize depression in the elderly, older Americans often don't recognize they are depressed, adds Boksay. "They are 70 or 80 years old and have never seen a psychiatrist or a psychologist; they think they are just old and it's normal to be sad. The food in the nursing home is lousy. They are becoming frail. The elderly will rarely tell you that they are depressed. You have to tell them and treat them anyway."

What are some possible indications that your elderly patient might need treatment for depression? Boksay agrees with Cowley that symptoms of depression often are overlooked or misunderstood. The elderly don't exhibit the symptoms of depression seen in younger patients, such as loss of appetite, lack of sleep, and fatigue, they note.

If your patient appears to have an excess disability, suspect depression, says Boksay. "If you have been to the hospital and seen 10 patients recovering from a mild stroke. Nine of them are up walking around, and one refuses to get out of bed — [he is] impaired more than [his] medical condition seems to merit — depression may be present."

In addition, if your patient makes excuses for not resuming activity, don't ignore it: Suspect depression. "Dementia doesn't do that. Your patient with dementia may go in the corner and pee, but that patient won't refuse to get up and walk to the corner," says Boksay.

Elderly patients treated with the wrong drug actually may exhibit drug-induced reactions with the appearance of dementia, which is the reason an accurate diagnosis by a geriatric psychiatrist or psychologist is so vital, cautions Cowley. "If a patient has a mild anxiety disorder but is treated with an antipsychotic drug, it often makes them look as if they have Alzheimer's when they don't," he says.

Depression also may be an important early clinical indicator of future Alzheimer's in an elderly patient, which is just one more argument for early diagnosis and aggressive treatment of geriatric depression, adds Boksay. "Many older adults have age-related or mild forgetfulness, but only 50% of those older adults ever develop Alzheimer's. It takes about five to seven years to develop Alzheimer's. Now, we are able to better identify the 50% who will develop Alzheimer's by identifying certain risk factors."

Those risk factors include:

- depression;
- family history of Alzheimer's;
- poor blood flow;
- major medical problems;
- hypertrophy of the brain.

If you have an elderly patient with mild forgetfulness and at least one other risk factor for Alzheimer's disease, Boskay suggests starting one of several drugs that slow cognitive and functional decline, such as cholinesterase inhibitors combined with vitamin E, or even some ginkgo biloba. ■

## *Resource Bank*™

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

# Video sheds light on living with disability

Fanlight Productions in Boston recently released a video in which women with disabilities, particularly spinal cord injuries, offer insights on living. "Not Just Surviving: Women Living a Full Life With a Spinal Cord Injury" addresses topics of importance to women such as rehabilitation, working with health care providers, appearance and sexuality, contraception, pregnancy, parenting, and menopause. The video brings together four women who have been living with spinal cord injury for more than 15 years. The women speak about their experience with spinal cord injury and about what they have found to be the key to living a full life after their accidents.

The 40-minute video sells for $145 plus shipping and handling. It also can be rented for $50 a day. To order or for more information, contact Fanlight Productions, 4196 Washington St., Suite 2, Boston, MA 02131. Telephone: (800) 937-4113. Web site: www.fanlight.com. Order #DD-273. ▼

# Check out this consumer guide on assisted living

The Consumer Consortium on Assisted Living (CCAL) in Arlington, VA, recently released *Choosing an Assisted Living Facility: Strategies for Making the Right Decision*. The guide is designed to help individuals choosing an assisted-living facility identify and explore the issues necessary to select a good one.

Topics covered in the consumer guide are: costs and contracts, personal care, health care, transportation, activities and socializing, meals, safety, facility-initiated discharge, accessibility, and special care units.

The 25-page booklet sells for $5. Bulk orders of 25 booklets are available for $50. To order, or for more information, contact CCAL, P.O. Box 3375, Arlington, VA 22203. Telephone: (703) 841-2333. Web site: www.ccal.org. In addition, you may join CCAL for $30 and receive its quarterly newsletter with discussions of assisted living issues, news and updates. ▼

# Project offers quick tool for nutrition issues

The Nutrition Screening Initiative in Washington, DC, recently released "Nutrition Care Alerts," a pamphlet that provides warning signs and action steps for nutrition-related health problems.

The pamphlet includes information on four nutrition-related health issues: unintended weight loss, dehydration, pressure ulcers, and tube-feeding complications. For each of the four conditions, the pamphlet lists warning signs followed by suggested action steps for members of the care team.

Action steps are divided into two sections. The first includes suggestions for nursing assistants or family caregivers. The second provides suggestions for members of the interdisciplinary care team, such as nurses, dietitians, and physicians. The pamphlet was written with nursing home residents in mind but is also appropriate for home health patients.

The Baltimore-based Health Care Financing Administration has agreed to begin pilot testing the "Nutrition Care Alerts" to gauge their effectiveness in the field before the end of the year. For a copy of the pamphlet and an order form, contact Nutrition Screening Initiative, 1010 Wisconsin Ave. N.W., Suite 800, Washington, DC 20007. ▼

# Risk management firm launches new Web site

Health Risk Management (HRM), a health care consulting and benchmarking company in Minneapolis, recently launched its expanded Web site that includes interactive features. The Web site includes a built-in calculator to help health plans determine the effectiveness of medical management efforts, and secured client sites with training modules for HRM's evidence-based clinical decision support guidelines.

For details, visit the site at www.hrmi.com. ▼

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**Editorial Questions**

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# New JCAHO manual helps with accreditation

Leaping the Joint Commission's hurdles to accreditation can be made easier with the newest edition of *Strategies for Successful JCAHO Homecare Accreditation 1999-2000.* This newest edition is a step-by-step guide to compliance with the Joint Commission on the Accreditation of Healthcare Organizations' 1999-2000 standards. Its 573 pages provide strategies and documentation tools to help you prepare for accreditation and include dozens of forms, checklists, staff education documentation, and management tools.

The guide also features case studies with tips and advice from your peers who have survived the survey, plus a list of vendors approved by the Joint Commission to measure outcomes. With your purchase of the new guide, you can receive 25 nursing continuing education credits free. You also have the opportunity to buy unlimited additional CE programs for just $40 each. Call (800) 688-2421 or e-mail American Health Consultants at customerservice.ahcpub.com. ■





## CE objectives

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

1. Implement five proactive strategies for protecting their professional licenses and credentials.
2. Describe four functions of case managers required by the Little Rock-based Case Management Society of America's Standards of Practice.
3. List the symptoms of post-traumatic stress disorder. ■