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Long-Term Management of Traumatic Brain Injury

State trust funds fill gaps in services for traumatic brain injury survivors

Here's how advocacy groups partnered to provide long-term solutions

Traumatic brain injuries (TBI) often leave survivors with long-term cognitive, emotional, behavioral, and physical disabilities that create such a wide range of needs that no one payer or funding source could possibly meet them. Advocacy groups, survivors, and their families in 10 states — frustrated by gaps in services for TBI survivors — have successfully spearheaded grass-roots efforts that resulted in brain injury trust funds.

Those trusts are funded by traffic violation and drunk driving fines and provide a variety of grants and services that benefit TBI survivors and their families. In addition, the legislative process creates secondary gains that benefit case managers and their clients. **(A complete list of states with brain injury trust funds appears on p. 40.)**

The high, long-term cost of TBI

Every 15 seconds, someone in the United States sustains a traumatic brain injury (TBI), which results in behavioral, emotional, cognitive, and physical impairments. An estimated 5.3 million Americans live with disabilities resulting from brain injury, according to a 1999 study by the Centers for Disease Control and Prevention. The study reported that each year, 80,000 Americans experience the onset of long-term disability following TBI. The cost is estimated to be \$48.3 billion annually. Although payers generally cover the cost of acute care, and survivors are eligible for government disability insurance, TBI survivors have a wide range of long-term care needs that often are unmet. In this issue, you will find articles on government and private sector resources you can tap to help clients with TBI. ■

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“In Georgia, we had to have a referendum passed to establish the brain injury trust fund,” notes **LuRae Ahrendt**, RN, CRRN, CCM, a nurse consultant with Ahrendt Rehabilitation in Norcross, GA, and chair of the executive board for the Brain Injury Association of Georgia in Atlanta.

“The massive effort that took on the part of survivors, their families, nonprofit disability organizations, and rehabilitation providers established support networks that didn’t exist before. This is the real essence of rehabilitation and should be important to all case managers,” says Ahrendt.

A capitol idea

Case managers and others in the disability community who have banded together to establish brain injury trust funds in their states often reap more than one expected gain from the process. “Having a cause to do battle for also gives some TBI survivors the push they need to re-enter the community,” Ahrendt says. “I had one client, who had been very reticent to get involved in community activities after his injuries, actually bulldoze his way through the doors of the Georgia state capitol building during the effort to get the referendum passed.”

The legislative process also gives case managers and disability activists the opportunity to educate legislators about the long-term needs of brain and spinal cord injury survivors. “I think any time we have an opportunity to educate individuals about living with a disability, we should take it because we never know what long-term benefits may come as a result,” Ahrendt says.

“By working to pass the referendum, we have heightened the awareness of legislators in Georgia about the needs of TBI survivors and created a legislative legacy that we will utilize for many years to come,” she notes. “It has also caused an attitudinal shift by making legislators

and others in the private sector aware that TBI survivors have the potential to be maximally independent with appropriate support. What is often communicated in the legislative process is a sense of possibility and not a sense that we expect the state to take care of people with disabilities.”

Most states with brain injury trust funds provide survivors with community service coordinators who provide long-term case management services that support the survivor and family members long after the provider case manager and payer case manager are out of the picture.

“We serve more than 1,200 clients a year through the resource coordination program to individuals with brain and spinal cord injuries,” says Priest. “Service coordinators serve 25 to 28 families a month, but we don’t close a case unless a client specifically requests us to, a client dies, or a client moves out of state. We are always available to help that patient at any time.

“Typically, upon referral, we spend a great deal of time identifying needs and developing resources to meet those needs. After a few weeks, the amount of effort a coordinator spends on the client decreases from eight hours a week to several minutes until a time when a coordinator may only hear from a client once in every three or four months.”

The contract that the state of Tennessee Traumatic Brain Injury Program signed with the Brain Injury Association of the Mid-South (BIA) in Memphis, TN, mandated that the community service coordinator serve a minimum of 25 clients annually. In reality, **Carolyn S. Chambers**, MS, CRC, the community service coordinator with BIA of the Mid-South currently has 200 active files. “There are files I have open for people who don’t contact me for months, but who still occasionally have problems,” she notes. “Sometimes, survivors do well for years and then run up against an issue they need my help with.”

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Chambers remembers a 20-year TBI survivor who had put herself through a PhD program while raising her child as a single parent. “She’s an educator, and everything was going smoothly until she ran into a problem with her employer, who didn’t understand her special needs,” Chambers says. “The problem is a TBI survivor often looks normal. To an outsider, there are no visible signs of their unique disabilities.”

In this case, the woman was working as a college professor and was having difficulty teaching classes late in the day as well as adjusting to changes in class schedules, which were 40 minutes long some days and 120 minutes long on other days. “She would get confused about when to let her class out. Sometimes, she dismissed students early and other times she kept them late.”

In addition, the client was uncomfortable sharing office space with another professor. “She was easily distracted and had trouble concentrating when she shared space with another professor,” Chambers explains.

She met with the woman’s department head to work out a more reasonable class schedule and office sharing arrangement. “We agreed to a schedule that allowed her to share both a computer and office space with another professor but schedule their respective office hours so that they never were in the office at the same time,” she says. “It’s often a matter of education. Few people without a personal experience with TBI understand the physical, emotional, and cognitive challenges these people face.”

A wake-up call

Another of Chambers’ clients had successfully completed her rehabilitation and was holding down a full-time job, but she was having difficulty waking up in the morning and was in danger of losing the job. “She was very worried. She told me she had placed alarm clocks in every room in her house but simply couldn’t wake up on time in the morning. A brain stem injury doesn’t heal in a nice, predictable manner like a broken femur,” says Chambers.

It took Chambers several telephone calls to local home health agencies and companion services before she found one willing to send someone to the client’s house with a house key to

wake the client and stay long enough to make sure the woman was dressed and ready for work.

It’s not unusual to find TBI survivors who run into difficulties just when they appear to be fully recovered, cautions Chambers. “Almost every brain injury survivor reaches a point where they think they don’t need their medications anymore, and the results can be disastrous,” she says. “I get lots of calls from clients who end up in jail because they’ve stopped their medications and end up in a fight, or get picked up for drunk and disorderly conduct.”

Think long term

In those cases, Chambers says the case manager has two jobs. “First, you have to explain to law enforcement officers that things may not be what they appear,” she notes. “Second, you have to convince the client to go back on their medications.” The unpredictable nature of TBI makes it mandatory for case managers to contact clients for follow-up, she says.

“I review client files on a quarterly basis, even those who don’t have active, ongoing needs. Sometimes, you find that they’re doing well and haven’t called because they don’t need help at the moment. Other times, you call and the client really needs you but has lost your phone number or can’t remember your name. They know someone helped them, but they can’t remember who,” she says.

Ahrendt agrees and adds that case managers must educate survivors and their families about the long-term and unpredictable nature of TBI. “Not enough emphasis is placed on looking at the long-range needs of TBI survivors,” she says. “It’s a key role of the case manager to educate the survivor and family well beyond what they perceive as their immediate needs. Families should expect both internal and external case managers to provide them with that information.”

In Florida, the trust fund also provides for community service coordinators and nurse case managers for injured children.

“Children need to be actively case managed for a longer period of time than most adult TBI survivors,” says **Bonnie G. Wirth**, RN, CRRN, the community health nursing consultant for Children’s Medical Services in the Department of Health in Tallahassee, who supervises the 11

nurse case managers who work with brain and spinal cord injured children in Florida.

“The injury impacts the child differently at each developmental stage,” she says. “There is a great deal of work that needs to be done with families and school systems. If we can get children back to school and placed at an appropriate level so that they can be successful, it’s the best thing we can do for the child and the family. If the child is back in school, the parents get a needed break but also an opportunity to go back to work full or part time.”

Community service coordinators must be particularly resourceful. Most states with community service coordinators establish strong relationships with local nonprofit agencies, churches, and advocacy groups. Even then, some service coordinators cast their nets wide to help meet their clients’ needs.

Most state trust funds provide little money for direct services to TBI survivors, which means that community service coordinators must be creative and flexible. **(For a look at how three state trust fund programs gather and spend their money, see p. 41.)**

The community steps in

Charlie D. Priest, executive director of the Alabama Head Injury Foundation in Birmingham, recalls one Alabama community service coordinator who convinced the local Automobile Dealer’s Association to donate an accessible van for a TBI survivor. “The van was awarded to the survivor and his family during a minor league baseball game. The Automobile Dealer’s Association received some good public relations mileage out of it.”

You never have enough money to meet all of a client’s needs, agrees Wirth. “I really applaud our community service coordinators who often go out into the community and persuade the local Rotary Club or Kiwanis to assist a client with home modifications or to donate items.”

Sometimes community service coordinators approach private corporations for donations, she adds. “One company purchased tricycles whose pedals could be operated by hand for children with spinal cord injuries. Those are things that go beyond meeting basic needs and impact quality of life.” ▼

10 states now have TBI trust funds

Federal government also provides resources

Ten states now have traumatic brain injury (TBI) trusts designed to fill gaps in services and benefits provided by other funding sources available to survivors and their families. In some states, the trust fund provides services and grants to both TBI and spinal cord injury survivors. The state office that administers the trusts — and the services provided by them — varies greatly from state to state and ranges from funding home modifications to providing grants to recreational day programs. All 10 state trusts are funded by additional surcharges on traffic violations and/or drunk driving convictions.

However, the trust funds are not a panacea for the many unmet needs of TBI survivors. In addition, it’s important for case managers to help their clients explore all other funding options first. “The state trust funds are payers of last resort,” notes **Charlie D. Priest**, executive director of the Alabama Head Injury Foundation in Birmingham, which spearheaded the effort that established Alabama’s brain injury trust fund in 1992. “The trust funds do not supplant other funding sources. They’re not going to pay for something that a federal program or an insurance company is available to pay. The intent of the trust funds is to fill gaps in service to citizens of the state with TBI.”

The funding packages for individuals with disabilities are increasingly diverse, and brain injury trusts are just one source case managers need to make clients aware of, agrees **LuRae Ahrendt**, RN, CRRN, CCM, a nurse consultant with Ahrendt Rehabilitation in Norcross, GA. “Private insurance remains the primary source for people through acute care and rehabilitation. Other sources include Medicaid and Medicare. It’s when traditional funding sources fail to fill a need that grants and trusts assist survivors. The trusts have added another level for providing services.”

In alphabetical order, states that currently have trust funds for TBI survivors are Alabama, Arizona, California, Florida, Georgia, Kentucky, Louisiana, Massachusetts, Tennessee, and Texas.

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If you are unfamiliar with the TBI trust fund administrator for your state, your state chapter of the Alexandria, VA-based Brain Injury Association (BIA) is a good place to start. The state chapters of the BIA have strong alliances and, in most cases, also have contractual arrangements to provide trust fund services in their states. For a complete listing of state chapters of the Brain Injury Association with contact information, visit the BIA Web site at www.biausa.org or call (703) 236-6000.

Tech Act offers another option

In addition to state-funded trust funds, the federal government provides support services through the Assisted Technology Act of 1998, or Tech Act. There are 56 programs funded by the Tech Act, and they are located in all 50 states, as well as every U.S. commonwealth and territory. Tech Act programs provide consultation and technical assistance to schools and businesses to help them accommodate disabled individuals.

Some state Tech Act projects provide low-interest loans to help individuals purchase assistive technology; others lend individuals equipment while they wait for an equipment delivery or their own equipment is being serviced. "Thirty-three states have financial loan programs to allow individuals who are either not eligible for other programs or simply don't want to go through the hassle of applying for equipment through another agency," explains **Nel Bailey**, MS, director of the Technical Assistance Project for the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) in Arlington, VA, which has a federal contract to help the state programs implement their Tech Act projects. "The loan process is overseen by a consumer board, which screens individuals and makes loan recommendations.

"The state projects also have lending closets. They allow individuals to borrow equipment for a short term. In addition to helping out when equipment is being serviced, it's also a way for individuals to test a piece of equipment to see if it suits their needs," Bailey explains.

Tech Act projects also advise schools about assistive technology issues for students with disabilities and provide training for teachers. "We try to let teachers know what is available and

how to get funding for assistive technology," says Bailey.

Unfortunately, the office responsible for running the state Tech Act project is different for each of the 56 projects, often making it difficult for case managers to locate the Tech Act project in their clients' home states. "Some programs are housed in the state department of vocational rehabilitation, some are located in the state department of education, and some are housed in universities," she notes. "The easiest way for a case manager to find the right Tech Act project is to call RESNA or visit our Web site."

[For more on the Tech Act, or to locate a specific state project, contact RESNA, 1700 N. Moore St., Suite 154, Arlington, VA 22209-1903. Telephone: (703) 524-6686. Fax: (703) 524-6630. E-mail: info@resna.org. Web site: www.resna.org.] ▼

How three states gather and spend fund dollars

Each of the 10 states that now has a brain injury trust fund allocates the money raised differently. Although all 10 states receive money from traffic violations, there is a great variation in how — and how much — is gathered. Here's a quick look at how three states operate their brain injury trust funds.

The state of Florida has one of the most established trust fund programs in the nation. In 1993, legislation passed that merged the state's existing Spinal Cord Injury Program with the Brain Injury Program to create the Florida Brain and Spinal Cord Injury Program, which was given budget authority from the governor for \$17 million for the year 2000.

The sizeable funds are generated through a variety of traffic fines and other sources:

- \$1 for each temporary license tag issued in the state.
- 8.2% of every traffic-related civil penalty.
- \$60 for each driving under the influence (DUI) and boating under the influence conviction.

The trust fund provides a wide range of direct

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and indirect services for traumatic brain injury (TBI) survivors, but the heart and soul of the program are the brain and spinal cord injury registry, says **Thom DeLilla**, CDMS, CIRS, program administrator for the Florida Brain and Spinal Cord Injury Program in the Florida Department of Health in Tallahassee. “The registry requires every hospital in the state to report new TBIs and spinal cord injuries within five days. The information is reported to this office, and within 10 days survivors and their families are contacted by the trust fund office to initiate services.”

Case managers and service coordinators initially work with families and survivors to help them identify resources. “That’s the important thing. Families are confused at this point. Life doesn’t look very promising. We just want them to know support is available,” says DeLilla.

Other services provided by Florida’s trust fund include:

- direct funds for rehabilitation;
- prevention programs;
- home and van modifications;
- two statewide resource centers;
- funding for research on TBI and TBI prevention provided to local universities;
- community service coordinators for long-term case management needs. **(For more information on community service coordination programs, see cover story.)**

The Alabama brain injury trust fund was established by a series of legislative efforts that began in 1992. “The first piece of legislation established a 17-member advisory board and charged them with the responsibility for investigating the needs of people in the state with TBI,” explains **Charlie D. Priest**, executive director of the Alabama Head Injury Foundation in Birmingham, which spearheaded the effort that established Alabama’s brain injury trust fund in 1992.

It took several years and additional legislation before funds actually were released to survivors beginning in 1995. “This year, we passed still another piece of legislation that provides an additional fine of \$100 for every reckless driving conviction. Even after a state trust fund is established, you have to keep looking for new ways to fund and protect it,” he notes.

The Alabama trust also receives \$100 for every

drunk driving conviction in the state and operates a budget of about \$2 million annually.

Services provided with those funds include:

- personal assistant services;
- long-term supported employment of up to \$1,500 annually to help employers accommodate injured employees;
- vocational rehabilitation programs;
- community support network and resource coordination.

The Tennessee Department of Health in Nashville houses the state’s Traumatic Brain Injury Program, which was established in 1993.

Tennessee

The trust fund receives \$2 for every speeding ticket, \$25 for every reckless driving conviction, \$10 for every DUI conviction, and \$10 for every revoked license conviction, which totals to an operating budget of about \$600,000 annually.

Roughly half of that money pays for the trust fund staff and the state’s brain injury registry, says **Jean Doster**, program director of the Traumatic Brain Injury Program. The remaining \$300,000 provides grants to programs that support TBI survivors and their families. Some examples of grants awarded by the trust include:

- \$40,000 a year for three years to expand a day treatment program;
- \$40,000 a year for three years to support the development of an accessible housing project that provided homes for 24 disabled individuals;
- \$100,000 a year for three years to a community mental health center to provide in-home counseling and behavioral intervention for TBI students in 24 counties in middle Tennessee;
- \$100,000 a year for three years to the Tennessee Emergency Services for Children Project to improve the capability of 54 rural hospitals to provide quality care in the early management of acutely injured children;
- \$75,000 a year for three years to provide supported living services, such as personal attendant care for six residents of the accessible housing project;
- \$45,000 a year to pay the salary, office space, travel expenses, and direct training of community service coordinators.

“The legislation mandated that we develop a statewide case management system for TBI survivors. Since it is difficult to establish new state positions, we provide grants to local nonprofit

agencies, including the Brain Injury Association of the Mid-South in Memphis, to hire the coordinators,” notes Doster, adding that the state trust fund currently supports six community service coordinators. “Through the grants, we can provide direct services to individuals. They also allow us to develop pilot programs and see what works and what doesn’t work to meet the needs of our state TBI population. The service coordinators submit quarterly and annual reports to us, and we conduct site visits at least once a year.”

In addition, the trust fund awards smaller one-year or one-time grants, such as a \$5,000 grant to regional health departments for TBI prevention programs. ▼

Recycling center is CM gold mine

All you have to do is ask

Like the Santa Claus he plays each year at Christmas, **Ed Butchart**, executive director and founder of Friends of Disabled Adults and Children (FODAC) in Stone Mountain, GA, has filled the wish list of many traumatic brain injury (TBI) survivors and their families.

TBI survivors often are left with drastically reduced financial resources. Not only are the rehabilitation costs staggering, but if the family breadwinner is the TBI patient, he or she may never return to full employment, leaving the family with reduced income.

Although many states have brain injury trust funds to which case managers can refer patients for additional services and support, there are always unmet needs for items such as assistive technology, transportation, or medical equipment. Next time that happens, case managers may wish to pick up a phone and call Butchart. **(For more on brain injury trusts, see article on p. 41. For a list of states with trust funds, see p. 40.)**

“We don’t ask about a person’s circumstances. There’s no eligibility requirement here. If you call and say you need something and we have it, it’s yours,” he says. “If we don’t have it, we put you on a waiting list and call you when it comes in.”

Butchart describes his nearly 5,000-square-foot

warehouse as a “big recycling center.” FODAC accepts donations of used medical equipment, medical supplies, computers, and assistive devices the organization refurbishes and then gives away to those who need them. “We have people using our wheelchairs in 34 states and more than 50 countries,” says Butchart. “If a person is alive and has a need, we try to fill it. Our services are limited only by our ability to fund them.”

“I’ve had many clients who have received items such as tilt tables from FODAC,” notes **LuRae Ahrendt**, RN, CRRN, CCM, a nurse consultant with Ahrendt Rehabilitation in Norcross, GA. “They have a workshop there for people with disabilities where they redo used equipment. Several of my clients have also worked over at the FODAC shop.” Ahrendt urges case managers to continue to search for resources such as FODAC. “Case managers have to continue to look at their role as including locating multiple funding sources. We are not going to meet the many needs of these patients by managing the funds of a single payer. Providing information on organizations like FODAC to patients and families is one of our responsibilities.”

[To contact FODAC, call (770) 491-9014. More information on the organization is available on the FODAC Web site at www.fodac.org.] ▼

TBI resources for CMs and survivors

Both the national office of the Brain Injury Association (BIA) in Alexandria, VA, and the national office of the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) in Arlington, VA, have extensive catalogs of useful resources for both case managers and consumers.

The following resources are available from BIA. To order, contact BIA, 105 N. Alfred St., Alexandria, VA 22314. Telephone: (703) 236-6000. Fax: (703) 236-6001. Web site: www.biausa.org.

• **The TBI Tool Kit.** Item No. 2TKTB. Cost: \$24.95. This 212-page manual includes a comprehensive list of federal and state resources and how to qualify for them. Also, the manual provides the

framework for gathering the information needed to complete the application process required by various agencies. It also discusses how to appeal, if you are denied funds. The manual appendix lists contact names, addresses, and telephone numbers of federal and state agencies, advocacy groups, and assistance organizations.

- **Life Care Planning and Case Management Handbook.** Item No. 4LCPH. Cost: \$89.95. This 528-page book addresses the medical, economic, and legal issues for a variety of conditions, including brain and spinal cord injuries. The book includes case examples and checklists.

- **Life Care Planning for the Brain Damaged Baby.** Item No. 4LCPB. Cost: \$22.95. This 140-page manual provides a step-by-step approach to developing a comprehensive life care plan for the baby with brain injury. The material contains two complete sample life care plans and numerous checklists, charts, graphs, reproducible forms, and references to relevant readings.

- **Independent Living and Brain Injury.** Item No. 2ILBI. Cost: \$11.50. This 78-page text focuses on making services provided by government agencies or centers available to persons with brain injury through existing providers.

- **Coming Home: A Discharge Manual for Families of Persons with a Brain Injury.** Item No. 2F01B. Cost: \$12.50. This 70-page manual identifies and provides examples of common behavioral changes and offers practical strategies for dealing with problem areas. The manual provides ongoing advice for family members of brain injury survivors.

- **Community Living Skills Workbook for the Head Injured Adult.** Item No. 1COML. Cost: \$104. This 384-page book is a comprehensive resource for clinicians that provides treatment activities addressing the specific needs common to many persons with head injuries. The book includes functional activities for treatment within the environment to which the injured person will return. It includes reproducible forms and hand-outs.

- **Community Success.** Item No. 2COMS. Cost: \$49. This 1,777-page activity book illustrates 60 common activities such as crossing streets, using restrooms, and shopping in a step-by-step manner. Corresponding social skills are integrated into each activity. The material and illustrations follow a three-step process: review, rehearse, and perform. The pages can be photocopied for individual use. It includes easy-to-use reports for measuring a patient's progress.

- **When Your Child Goes to School After an**

Injury. Item No. 1AFTR. Cost: \$9.50. This 72-page book is a resource guide for parents, teachers, and caregivers. The guide offers practical suggestions for enhancing a child's successful return to school after an injury.

- **When Young Children are Injured: Families as Caregivers in Hospitals and at Home.** Item No. 1YNGC. Cost: \$9. This 49-page book offers families practical advice for choices and decisions that will help them adjust and prepare for the future.

The following resources are available from RESNA. To order, contact RESNA, 1700 N. Moore St., Suite 154, Arlington, VA 22209-1903. Telephone: (703) 524-6686. Fax: (703) 524-6630. E-mail: info@resna.org. Web site: www.resna.org.

- **Pediatric Powered Mobility.** Cost: \$20. This 94-page book provides current philosophies, research, and resource information for individuals seeking to provide powered mobility to children.

- **RESNA Resource Guide for Assistive Technology.** Cost: \$30. This three-volume set provides detailed information on measurement for assistive technology, assessment instruments, tools, and outcomes measurement.

- **Alternative Computer Access: A Guide to Selection.** Cost: \$30. This 280-page book is a guide to selecting computers for individuals with physical, cognitive, or sensory disabilities. The book describes computer access features and solutions and offers information on a range of equipment and products. ■

Workers' compensation

Phone triage program cuts comp costs

Nurses help workers decide when to seek care

Phoenix-based Compensation Value Alliance (CVA) has reduced workers' compensation costs by \$100,000 annually for a restaurant client through its Company Nurse telephone triage program. Romulus, which owns and operates 11 International House of Pancakes in Arizona and employs some 850 employees, says the telephone triage system is well-suited to the strains, sprains, cuts, and burns that make up the majority of its workers' comp claims.

“The Company Nurse program gives employees a level of comfort,” says **Chris Milisci**, president of Phoenix-based Romulus. “How many times have you been hurt or sick and not known whether to go in to see the doctor or not? Do you make an appointment, or do you talk to the doctor or the nurse first? I think employees don’t necessarily want to rush to the emergency room when they’ve been injured, but sometimes they’re not sure whether they need to or not. The Company Nurse helps them make the decision about whether or not to be seen by a doctor, and the nurses always err on the side of caution, so there’s little risk that an injury will not be properly treated.”

Romulus employees call the Company Nurse hotline and speak with a CVA nurse or paramedic, who gathers information on the injury and helps the worker decide whether to seek care and, if care is needed, where to obtain it. “In the past when someone was injured, the manager was notified immediately, and if it seemed severe enough that the person needed medical attention, we would immediately take the employee to the hospital,” says Milisci. “We didn’t want our managers making decisions about employee medical care, so a lot of people ended up being sent to the emergency room that may not have needed more than a bandage.”

Employees can speak privately with the nurse or paramedic at CVA. “The employee and the nurse make a decision about whether to seek medical care together,” Milisci explains. “The system brings a level of comfort to managers and employees. The nurse or paramedic can help dissuade the injured employee from seeking unnecessary care, yet the employee at any point can say, ‘I want to see the doctor.’”

Romulus’ employees are now comfortable with the Company Nurse program, but there was some dissatisfaction in the early days of the program, notes Milisci. “Initially, there were some long hold times when employees called the hotline. It’s no different from the hospital emergency room. When you go to the emergency room, you think you are the most important patient there. When employees called the hotline, they thought they were the most important caller, and they didn’t like being placed on hold.” Once the hold time issue was resolved, employees started using the triage program more frequently.

“Any snags that might exist when you implement a new program occur almost exclusively upon start-up when new procedures are being

put in place,” says **Steve Williams**, chief executive officer of CVA. “It is vital that supervisors and human resources personnel receive training on how the service works — trainers must clearly explain the program in a simple as 1-2-3 manner and support the training with instructional posters in the workplace.”

Romulus has been very pleased with the program’s results. In general, 23% of all injuries are referred for home care or first aid. Another 73% of injuries are referred to occupational or primary care physicians. Only 4% of injuries are referred to hospital emergency rooms.

A year of results

Between Sept. 1, 1998, and Sept. 1, 1999, CVA’s Company Nurse handled 113 employee injuries for Romulus with these results:

- 39 required first aid or home care and never became workers’ comp claims.
- Only four claims, or 3.5%, incurred indemnity expenses, compared to a state average of 18.2%.
- Romulus’ annual workers’ comp costs dropped from \$170,000 annually to \$70,000 annually. **(For a national study of the top cost-control methods in workers’ comp, see p. 46.)**

“Technology advancing almost daily enables instant communication. Nowhere is the ‘time is money’ adage more relevant than when first report of injury, triage, and claim processing are instantaneously synchronized,” notes Williams. “A case in point, industry statistics reveal that, typically, a six-day lapse exists between the time an injured worker is sent to the doctor and the employer collects and reports claim information, followed by up to 30 days for the adjuster to gather information from the employer, employee, and doctor. Compare that with our experience: report of injury, workers channeled to doctor, and the provider, employer, and adjuster notified all within an average of one hour and 11 minutes.”

In addition, Williams notes that industry figures show that claims costs escalate 48% when reporting is delayed 10 to 30 days. “Apart from time efficiency, a key cost-saving factor is the identification of injuries that need not become claims.”

Telephone triage systems also support case management by providing quality information quickly. “Having quality information quickly is the most important requirement in proper case management. Whatever that takes should be employed.”

Williams notes that telephone triage is “injury management, not case management” but is designed to perform the following two functions that support case management and reduce workers’ comp costs:

- Identify and manage injuries that don’t need a physician’s attention.
- Maximize the information provided to claim professionals and employers while minimizing the time it takes to disseminate it.

“Telephone triage is not designed to replace physicians or case managers. On the contrary, it is designed to help make their jobs easier and more efficient,” says Williams. ■

CM makes top 10 cost-control list

Both field and telephonic CM named

Telephonic case management and field case management are widely perceived by risk management professionals as helping to curb workers’ compensation costs. The 1999 RIMS Benchmark Survey, a national survey of 816 corporate risk managers conducted jointly by the Risk and Insurance Management Society and Ernst & Young, both of New York, placed both types of case management among the top 10 most effective methods of workers’ compensation cost control.

“This is the first year we’ve asked respondents to make an assessment as to which cost-control methods were effective,” notes **Sue Anne Mitro**, manager for risk and insurance for The Hillman Co., a privately held holding and investment company in Pittsburgh. “I’m hoping that organizations find this information useful for weighing which cost-control methods to try.”

Jim Gamble, senior manager in the business risk solutions practice at Ernst & Young, also hopes organizations will use the information to control their own workers’ comp costs. “I think it’s very useful to know what other organizations are doing to control costs and what they consider to be effective. It’s information others can use to assess steps they may or may not already have tried themselves.”

The survey was sent to RIMS members, select clients of Ernst & Young, and members of the American Society of Healthcare Risk Managers in Chicago. Respondents were asked to select the

Top 10 most widely applied workers’ compensation cost-control methods

Respondents were asked to select the most effective methods to control workers’ comp costs from a list of 19 possible methods. To compute the perceived effectiveness of the listed cost-control methods, researchers compiled an index in which selections for “most effective” were weighted twice as heavily as those for “second most effective.” Using this method, loss/accident prevention was considered to be most effective overall.

Methods are listed in order from first most effective to tenth most effective:

1. loss/accident prevention programs;
2. light duty programs;
3. medical bill review;
4. preferred provider organizations;
5. telephonic case management;
6. telephonic claim reporting;
7. field case management;
8. utilization review;
9. claim administration audits;
10. cost allocation.

Cost-control methods that did not make the top 10 list include:

- capitated medical costs;
- on-site nurses;
- job requirements analysis;
- industrial hygiene reviews;
- job placement services;
- fax claim reporting;
- safety rewards;
- vocational testing and counseling.

Source: 1999 RIMS Benchmark Survey compiled and published by the Risk and Insurance Management Society and Ernst & Young, both of New York. Cost of the survey is \$395 for RIMS members; \$445 for RIMS associates, and \$495 for nonmembers. To order, contact Insurance Publishing Plus at (317) 843-2523. Organizations that complete the 2000 Benchmark Survey receive a free copy. For details or to complete a survey, visit www.rims.org/general.

most effective, the second most effective, and the least effective methods for reducing workers’ compensation costs from a list of 19 methods commonly used in the workers’ compensation industry. (See box, above.) In addition, demographic information about the organizations was gathered, as well as general information about workers’ compensation costs.

The most commonly used method for controlling workers' compensation costs was loss/accident prevention efforts, which were used by 600 respondents of all sizes. After loss prevention, light duty and medical bill review were ranked "most effective" by more than 500 respondents. Light-duty programs were popular regardless of respondent size. However, bill review was more popular with respondents with revenues above \$50 million.

The survey also found that flat premiums and higher sustained losses have driven the average cost of risk in the United States up for the first time in six years. After reaching a low of \$5.25 per \$1,000 in revenue in 1997, the average cost of risk rose to \$5.71 per \$1,000 in revenue. Workers' compensation costs rose to \$1.96 per \$1,000 in revenues in 1998, compared to \$1.93 in 1997. ■

Managed care

Patients prefer doctors in open-model plans

Staff-model HMOs least popular with members

If you want satisfied plan members, allow your primary care providers to work with more than health plan, say researchers led by Dana Gelb Safran, ScD, director of the Health Institute of the New England Medical Center in Boston.

Researchers asked 6,000 Massachusetts state government employees who belonged to different models of health plans to rank the performance of their physicians in 10 categories, including access to care, continuity of care, physician's knowledge of their personal health, and how well their physician communicated with them.

Patients of staff model health maintenance organizations, plans with salaried physicians limited to treating the members of that plan, ranked their physicians the lowest in nine of the 10 categories. The only category in which the plans did not receive the lowest score was for preventive health counseling. Group model HMOs, which limit physicians to treating only members but pay them differently, performed slightly better than staff model physicians in all 10 categories, but not as favorably as open-model health plans.

Open-model plans, which do not restrict physicians to treating patients in only one plan, scored highest in all 10 categories. Open-model plans include managed indemnity insurance, which works like traditional fee-for-service insurance with some controls such as preauthorization for hospital admission; point-of-service plans; and network HMOs. Patients reported no difference in the quality of care received under the various open-model plans.

(See: Safran DG, Rogers WH, Tarlov AR, et al. *Organizational and financial characteristics of health plans: Are they related to primary care performance?* Arch Intern Med 2000; 160:69-76.) ■

Teens need one less hepatitis B shot

FDA approves two-shot vaccine

The Food and Drug Administration in Washington, DC, recently approved a two-dose regimen of Recombivax HB manufactured by Merck & Co. in West Point, PA. The two-dose regimen is an alternative to the three-dose regimen currently used for children from birth to age 19.

A retrospective study conducted by Merck in 1998 found that 54% of adolescents 11 to 12 years of age had never received any hepatitis B vaccine. Of those teens 11 to 12 years of age who started the three-dose regimen, Merck found that one in four failed to complete the regimen. Among those who did receive all three required doses, more than 90% did not receive the doses according to the recommended schedule and finished late. A company spokesman says the alternative two-dose regimen may help providers improve the vaccination coverage in this hard-to-reach population.

"Adolescents can be the hardest age group to fully vaccinate for hepatitis B," notes Tom Vernon, MD, vice president of public health and medical affairs for the Merck Vaccine Division. "Busy schedules leading to missed or postponed appointments, changes in physicians and health care plans, and fear of injections: These are real-world challenges which make compliance among adolescents difficult."

Roughly 90% of all hepatitis B cases occur in adolescents and young adults, according to the Centers for Disease Control and Prevention (CDC) in Atlanta. Vaccinating children ages 11 to 12 years

has been a health care priority in the United States since 1994, when the CDC Advisory Committee on Immunization Practices announced a new catch-up strategy to better protect adolescents against hepatitis B and other diseases such as measles, tetanus, and diphtheria. That new strategy was designed to reach teens who were born before 1991, when the hepatitis B vaccine was universally recommended for all children from birth to age 19.

“Seeking FDA approval for a two-dose indication for adolescents 11 to 15 years of age was Merck’s solution for reaching a particularly vulnerable population that might not otherwise receive all three doses of the standard regimen,” says Vernon.

(For more information, visit the Merck Web site at www.merck.com.) ■

Free brochures help patients select quality care

The Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, has published a series of free “Helping You Choose” brochures designed to help consumers select quality health care facilities. The brochures provide consumers with key questions to ask when selecting a health care facility, such as a hospital, outpatient center, or a long-term care facility.

Free copies of the brochures are available by calling the commission’s customer service center at (630) 792-5800. The brochures also are available at www.jcaho.org. Click on “Search,” then type in “Helping You Choose.” ■

Behavioral health/disease management

Identifying depression before it impacts health

Company hopes screening will boost outcomes

LifeMasters, a disease management provider based in Newport Beach, CA, recently added a depression screening tool to its disease management protocol for diabetes and cardiovascular disease. With the National Institutes of Mental Health in Bethesda, MD, estimating that depression is as high as 30%, or three times the national average, in adults with chronic illness, and that 50% of all individuals with depression are undiagnosed, LifeMasters’ philosophy is that identifying and treating depression will improve patient outcomes and save health care dollars.

“Depression is significantly more prevalent among those with chronic illness,” says **Jeffrey M. Davis**, MD, LifeMasters chief medical officer and developer of the company’s depression screening tool. “Without diagnosis and treatment, depression often gets in the way of individuals’ desire to effectively manage their health. Our tool gives them a way to remove this barrier.”

Disease management programs promote self-care in individuals with chronic illness, but

depression often causes lack of motivation, which hinders necessary behavior change and self-care activities, he notes. “Our interventions enhance self-care for individuals with chronic disease. More than 90% of the outcomes we achieve depend upon individuals and whether or not they comply with taking care of themselves and following medical directions,” says Davis. “We get a much bigger bang in terms of disease control if individuals understand their own disease and follow instructions for managing it. It requires behavior change, lifestyle change. If you take that and juxtapose it with depression, it’s clear that individuals who are depressed are not motivated to change. Depressed patients will tell you that.”

The tool is a nine-question quick screen administered over the telephone by LifeMasters nurses. “The screen is based on the DSM-5 [*Diagnostic and Statistical Manual of Mental Disorders*] depression criteria checklist. If a patient answers ‘yes’ to five or more of the nine questions, the nurse notifies the patient’s primary care provider and recommends that a further diagnostic assessment be conducted,” says Davis.

LifeMasters nurses contact patients at high to moderate risk for disease complications weekly during their first month of enrollment in a disease management program. Patients are assigned a primary care nurse and receive a packet that includes a photograph and a brief biography of the nurse to help facilitate a more personal connection between the patient and the nurse. At the

end of the first month of nurse mediated intervention, nurses administer the depression screen.

“We want to give the nurse time to develop a relationship of trust with the patient. There are things that patients are reluctant to share. We’re hoping that after four telephone calls, the patient will be comfortable enough with the nurse to answer the screening questions honestly,” Davis says. “The nurse explains that a mental health assessment is part of the reporting LifeMasters provides to physicians. The nurse does not tell the patient that we are specifically screening for depression.”

LifeMasters recently received permission from two of its clients to incorporate the depression tool into its disease management protocol for diabetes and cardiovascular disease. “Both plans are excited. Most qualified medical groups understand the role of depression in chronic disease, but physicians often don’t have the time necessary to address the issue with patients,” Davis says.

“We will be tracking how many screenings are positive and how physicians manage positive screens. We’re trying to give physicians data to better manage their patients, but whether outcomes improve for these patients depends on how their physicians use the information,” he explains. ■

Popular antidepressant now comes in liquid

The Food and Drug Administration in Washington, DC, recently approved an oral solution of Celexa, a selective serotonin reuptake inhibitor (SSRI), manufactured by Parke-Davis in Morris Plains, NJ, for the treatment of depression.

The oral solution is a welcome option for patients who have difficulty swallowing or who simply prefer liquid medications, notes **Steven Rose**, MD, professor of psychiatry at Columbia University College of Physicians and Surgeons in New York City. It may be especially useful for depressed patients who are elderly, including those in long-term care facilities.

“It is essential that elderly patients, especially those in long-term care facilities who require antidepressant medication, receive treatment that is not just effective, but also safe and well-tolerated,” he notes. “An oral liquid formulation of

Celexa will offer added convenience and ease of dosing for elderly patients who have difficulty swallowing pills or tablets.”

Celexa was introduced in late 1998 and quickly became the fastest growing SSRI, generating more new prescriptions in its first year than any previously launched product on the antidepressant market. More than 16 million patients have been treated with Celexa worldwide. The oral solution will be available commercially later this year. Full prescribing information for Celexa is available at www.celexa.com. ■

Prepare to enter new disease management era

Two pioneers say predictive models will reign

Many health care organizations rely on simple rules-based systems to identify patients who were at high risk yesterday and target them for disease management programs today. The problem is that these systems cannot identify the significant number of patients who will be at high risk tomorrow.

Predictive modeling does just that. “A predictive model uses whatever data you have available today — pharmaceutical, demographic, clinical, claims, health-risk appraisals — and uses those elements to perform a statistical analysis to prospectively identify those who will be at risk tomorrow,” says **Mark H.T. Ridinger**, MD, president and chief medical officer of Axonal Health Solutions in Washington, DC.

Axonal received a research grant from the National Institutes of Health in Bethesda, MD, to develop and test its predictive model system, called HealthAugur, which can run 15 chronic disease models and produce stratified risk results.

“As we discovered, when you rely on claims data rules-based logic to identify at risk members, you find only a small minority of patients had prior hospitalizations for asthma,” Ridinger explains. “When you simply identify this year’s high-risk asthmatics, you miss the vast majority of next year’s high-risk asthmatics. The real savings come if you can identify those asthmatics who are not yet high risk but will be in the future and plan appropriate asthma management interventions.”

Advanced predictive models generally increase the number of at-risk patients who are prospectively identified by anywhere from 25% to 100% over conventional screening methods. What does that mean to a health plan in terms of cost savings and improved outcomes? To illustrate the differences between rules-based risk identification and predictive modeling, Ridinger gives the following example based on Axonal's own research:

- A health plan with 200,000 covered lives has a population of 14,000 covered lives currently diagnosed with asthma.
 - Of those 14,000 asthmatics, 700 to 1,400 (5% to 10% of the asthma population) is identified as high risk.
 - The average cost of asthma management and treatment per covered life is \$500.
 - The average cost of asthma management and treatment per high-risk covered life is \$10,000.
 - Risk screening identifies 294 to 588 covered lives as currently high risk.
 - Predictive modeling identifies 420 to 840 covered lives as high risk.
 - Cost savings from correctly identifying high-risk patients is \$8,500 per patient, or the \$10,000 average cost of care for a high-risk covered life less the cost of disease management intervention.
 - Cost savings from modeling is between 54 cents and \$1.10 per covered life per year.

Meeting the 'gold standard'

Predictive models not only identify members at future risk for disease complications. They rank plan members from highest to lowest risk making it easier for plans to decide which patients to target for intense case management and which to provide with less-costly disease management mailouts, notes **Jeffrey J. Rice**, MD, JD, chief executive officer for Axonal, based in the company's Dallas office.

"Different organizations have different goals. Some organizations know they only have the resources to manage 100 patients. They can look at the predictive model and target the top 100 to receive case management intervention."

Predictive modeling requires an artificial intelligence (AI) neural network. The size of an AI expert system database and the need to constantly update it make it impractical for all but the very largest health care organizations to develop and implement their own AI systems, note Ridinger and Rice. **(A definition of neural**

Building your disease management vocabulary

The next phase in the evolution of disease management programs requires that you add a few key definitions to your vocabulary, according to **Mark H.T. Ridinger**, MD, president and chief medical officer for Axonal Health Solutions in Washington, DC, and **Jeffrey J. Rice**, chief executive officer in Axonal's Dallas office. Those definitions include:

- **Data mining.**

Data mining is a software-based process that uses artificial intelligence to find previously unknown patterns in large databases and uses that information to build predictive models.

- **Neural networks.**

Neural networks are a type of artificial intelligence that health care organizations can use to pinpoint and track patients who are moving up a risk scale. Neural networks use empirical reasoning rather than rules-based logic to uncover relationships between medical factors and disease.

- **Predictive modeling.**

Predictive modeling is the process of analyzing current data to prospectively identify defined outcomes. In disease management, the data for predictive models is derived from claims data, pharmaceutical data, survey data and clinical data. The predicted outcomes are selected to identify patients at high risk for defined events such as emergency room visits, hospital admissions, complications of disease or death. Predictive modeling is a mathematical representation of reality that creates a statistical link between data available today and the prediction of an event tomorrow. ■

networks and other terms vital to this new disease management era appear in the box, above.)

"It takes a large and knowledgeable information technology staff and clinical staff to run the type of neural network necessary for predictive modeling. It's fairly expensive and time-consuming to get through the learning curve," says Rice. "We spent more than two years on pure development. In addition, it takes a sophisticated operational environment and the appropriate expertise, including a good understanding of the clinical problems of the disease."

Some questions Rice suggests you ask as you work through the risk assessment vs. predictive

modeling and then the “buy or build” decision include:

- What is the return on your investment?
- What are the parameters for the models?
- What are the pros and cons of the different statistical and methodologic applications that are available?
- What advantages do advanced statistical tools such as artificial neural networks provide over linear regression techniques?
- What source or sources of data are most appropriate?
- Are the necessary outcomes data available at this time to build a predictive model?

If you do decide to outsource your predictive modeling needs, Ridinger urges that you carefully research the available medical predictive modeling products to see if they meet your “gold standard.”

All that glitters . . .

Questions he suggests you ask predictive modeling vendors include:

- How long has the company existed, and what is its financial status?
- What is the background of the company’s leadership? Is all the necessary information technology and clinical and health care industry experience represented among the company’s officers?
- Has the predictive model been scientifically validated? What is its accuracy?
- How timely is information returned and reported?
- How user-friendly are the reports generated?
- Is the model a robust one capable of generalizing to my population?
- Does the predictive model stratify individuals by risk, so that different levels of intervention can be matched with the appropriate risk categories?
- Is the model patient-specific rather than actuarial? **(For a list of companies marketing AI predictive modeling products, see box, above right.)**

“The continuum of care is a perfect arena for predictive modeling,” says Ridinger. “But the true potential of AI systems may not be reached until other barriers fall away and we have clinical data in a standardized and integrated electronic record, and a business philosophy which accepts that dollars spent now are worth thousands saved later.” ■

Start here for predictive modeling products

Several companies are pioneering predictive modeling products for the health care industry. Three companies with products currently in use by health care organizations nationwide include:

- **Axonal Health Solutions**, 1133 21st St. N.W., Suite 600, Washington, DC 20036. Telephone: (202) 887-5542. Fax: (202) 659-9412. Web address: www.axonal.com.
- **MEDai**, 602 Courtland St., Suite 400, Orlando, FL 32804. Telephone: (800) 446-3324. Fax: (407) 644-8175. Web address: www.medai.com.
- **ThinkMed**, 312 E. Wisconsin Ave., Milwaukee, WI 53202. Telephone: (414) 287-6000. Fax: (414) 287-6005. E-mail: info@thinkmed.com.

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Editorial Questions

Questions or comments? Call **Lee Landenberger** at (404) 262-5483.

FDA approves new epilepsy drug

The U.S. Food and Drug Administration (FDA) in Washington, DC, has approved levetiracetam tablets, a new medication for patients who continue to struggle for seizure control despite taking other seizure medication.

The FDA cleared the new medication as an add-on therapy for partial seizures with or without secondary generalization in adult patients with epilepsy. Levetiracetam is rapidly absorbed after oral administration and food does not affect the extent of bioavailability.

Steady state is achieved after two days of multiple twice daily dosing. In addition, levetiracetam is not associated with adverse drug interactions when used in conjunction with other anti-epileptic drugs.

Levetiracetam is marketed in the United States by UCB Pharma in Smyrna, GA, under the brand name Keppra. The drug comes in 250 mg, 500 mg, and 750 mg tablets and will be available in U.S. pharmacies this spring. ■

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CE objectives

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

1. Identify new funding sources for long-term management of traumatic brain injury survivors.
2. Describe how telephone triage programs can reduce workers' compensation costs.
3. Differentiate between conventional risk screening and predictive modeling.
4. Define new terms in health care information systems, including neural networks and data mining. ■

Resource BankTM

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

Missed that conference? Check this out!

CancerEducation.com provides cancer education materials for health care professionals and consumers at www.CancerEducation.com. The site also now provides entire conferences on-line in full video format.

Two recent conferences available on-line at CancerEducation.com include:

- The First International Kidney Cancer Symposium, which included sessions on surgery for renal cell carcinoma, biology of renal cell carcinoma, anti-tumor immune response in renal cell carcinoma, and therapeutic approaches to advanced renal cell carcinoma.
- The Brain Tumor Foundation's Fourth National Symposium, which included sessions on brain tumor treatment in the next millennium, meningiomas, pediatric malignant tumors, seizure management, and consultation and collaboration with schools. ▼

Disability guidelines now include costs

The Corpus Christi, TX-based Work Loss Institute recently released its *Official Disability Guidelines 2000* and, for the first time, this fifth anniversary edition of the guidelines includes benchmark workers' compensation indemnity costs, direct plus indirect, for every workplace occurrence. The costs provide data to quantify potential savings from efforts such as case management and return-to-work programs.

The guidelines provide return-to-work norms for each illness or injury listed. The database was created by linking several federal government databases, including the Occupational Safety and Health Administration, the Centers for Disease Control and Prevention, and the National Hospital Discharge Survey with the worldwide ICD-9 coding system; it includes more than 3 million cases. The guidelines include "best practices"

developed by an editorial advisory board consisting of medical directors from some of the nation's largest employers. The best practice guidelines are updated annually to reflect the newest therapies and technologies.

The new edition also includes these features:

- physical therapy guidelines, indicating recommended frequencies and durations;
- key word index, making it easy to find any disease, procedure, injury, or condition.

The guidelines cost \$165 for the 1,200-page soft-cover book. They also are available on CD-ROM for \$195 or in an abbreviated text titled *Official Disability Guidelines — Top 200 Conditions* for \$79.

Orders should be sent to Work-Loss Data Institute, 500 N. Shoreline Blvd., Suite 1101-N, Corpus Christi, TX 78471. Telephone orders: (800) 488-5548. ▼

Can you compete with your peers in case management?

It's not too late to enter the fourth annual Best Disease Management/Service Practices Awards program, sponsored annually by Parke-Davis Healthcare Management in Parsippany, NJ.

The best practices program was initiated to encourage health care organizations to improve the efficiency and quality of their provider performance. Eligible participants include medical directors, directors of case management, directors of customer service, pharmacy directors, and directors of quality assurance, as well as other members of the health care team. To stimulate ideas, a contest entry kit has been produced that contains helpful hints from previous award recipients. Participants also are directed to a Web site, www.pdbestpractices.com, that lists ideas from the last two contests.

The program offers awards for outstanding ideas, services, or practices, in each of seven categories: depression, diabetes, epilepsy, hyperlipidemia, hypertension, infectious disease, and women's health.

All entries will be published in a *Y2000 Compendium of Best Disease Management and Best Service Practices*. The book will be distributed to managed care organizations throughout the country to give health care professionals the opportunity to adapt proven successes to their patient care and service.

A \$350 award will be given to five winning entries in each category. In addition, if one or more of a participant's entries are published in the compendium, the participant will receive a \$50 honorarium. Entrants can be winners in more than one category and every applicant will receive a commemorative wall plaque.

Entries are accepted by mail or e-mail. An entry form is available from Parke-Davis Best Disease Management Service Practices Awards, c/o Louis Scott Associates, 201 W. Passaic St., Suite 401, Rochelle Park, NJ 07662. The form must be included with each submission. All entries must be submitted by March 31. ▼

WEB ALERT



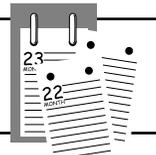
New site for children with bipolar disorder

The Child & Adolescent Bipolar Foundation (CABF), a Web-based organization incorporated in California, recently launched an interactive Web site with an extensive library, message boards, chat rooms, an ask-the-expert feature, and a drug database for children with bipolar disorder.

CABF was established by a steering committee representing several hundred families throughout the United States, Canada, and Great Britain, who met on the Internet. CABF's professional advisory board includes Kay Redfield Jamison, PhD, a professor of psychiatry at Johns Hopkins Medical School in Baltimore, and Joseph Beiderman, MD, an expert on attention deficit hyperactivity disorder and bipolar disorder from Harvard School of Medicine in Cambridge, MA.

Information regarding early-onset bipolar disorders can be found on CABF's Web site at www.bpkids.org. ▼

CALENDAR



• **March 29-31.** Celebrating a Decade of Promoting Quality in Health Care: A Quality Summit, the national conference sponsored by the American Accreditation Healthcare Commission/URAC in Washington, DC. Renaissance Hotel, Washington, DC. Cost is \$695 for URAC-accredited organizations and \$750 for non-accredited organizations. Sessions include:

— Case studies: How one New England community prepared for HIPAA compliance/partnering to develop a health management strategy.

— Innovations in technology for disease management programs.

— A legal overview of case management and utilization management.

Contact URAC, 1275 K St. N.W., Suite 1100, Washington, DC 20005. Phone: (202) 216-9010. Fax: (202) 216-9006. Web site: www.urac.org.

• **April 11-12.** Customer Service for the Healthcare Industry: The Challenge of Building Patient Loyalty in the New Era of Consumerism. Renaissance Parc Five Hotel in San Francisco. Sponsored by HealthCare America, a division of Saddle Island Institute in Boston. Cost \$875 per person. Pre-conference workshops also are available. Sessions include:

• Beyond patient care: Thriving in competitive times.

• Customer loyalty: How to earn it; how to keep it.

• Identifying customer dissatisfiers and countering them: Removing the ceiling from performance improvement.

Contact Healthcare America, 167 Milk St., No. 445, Boston, MA 02109. Phone: (617) 742-1740. Fax: (617) 742-1783. E-mail: sreynolds@hcamerica.org. ■

Send us *Resource Bank* items

If you have a new resource, conference, or seminar of interest to other case managers, send items for publication to: Lauren Hoffmann, Editor, *Case Management Advisor*, P.O. Box 740056, Atlanta, GA 30374. Telephone: (770) 955-9252. Information on conferences and seminars must be received at least 12 weeks before the event to meet publication deadlines. ■