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American Health Consultants® is
A Medical Economics Company

Professional development

Are you e-mailing your way into treacherous waters?

Develop Internet policies that comply with proposed HIPAA rules

The Internet is changing the face of health care delivery in the United States. It provides a convenient and efficient method of communication among providers, patients, and payers, as well as tremendous opportunities for managing patient care and monitoring long-term progress of the chronically ill. However, experts at two recent health care conferences caution case managers that the Internet's convenience doesn't come without risk. The biggest potential pitfall may come when the government's final patient health information protection regulations are released.

More than 20 sessions at the recent National Managed Health Care Congress (NMHCC) in Atlanta were devoted to health care Internet opportunities. In addition, health care attorneys at both NMHCC and the fifth annual Hospital Case Management Conference — also held recently in Atlanta and co-sponsored by American Health Consultants, publisher of *Case Management Advisor* — cautioned case managers that the time to develop Internet privacy policies is now, before the draft of the proposed Health Insurance Portability and Accountability Act (HIPAA) becomes final. (A summary of the proposed HIPAA rules is on p. 97. See also, *Case Management Advisor*, May 2000, pp. 73-81, for a special report on Internet health care issues.)

"The increasing role of computerized and electronic data systems and data transmission is going to be the hottest issue facing health care in the next couple years," says Vicki Myckowiak, JD, a health care attorney with Myckowiak Associates in Detroit who spoke at the Hospital Case Management Conference. "Under HIPAA, the government issued a law that regulates electronic health information, and it's going to be a law you

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need to be very aware of in the next couple of years. Medical data collected and used to treat patients, and a case manager's work, [which] revolves around that collection and coordination of medical data, is protected under HIPAA, which carries both monetary and criminal penalties for violations of protected information."

Case managers also should be concerned about protecting patient privacy on the Internet because patient anxiety about privacy issues is a potential barrier to care, adds **Jan Lori Goldman, JD**, director of the Health Privacy Project at the Institute for Health Care Research Policy at Georgetown University in Washington, DC.

"Studies indicate that anxiety about privacy causes one in six people to withhold information from their doctors, provide inaccurate information to their doctors, or practice doctor-hopping," she notes. "It's the equivalent of an individual keeping money under their mattress because they don't trust the banks to keep it safe."

Risky business

There is a risk when patients practice those types of information sharing, adds Goldman, who spoke on Internet privacy at the recent NMHCC conference. The information may lack integrity, which could place patients at risk.

"If information is inaccurate or incomplete upfront, then as it moves through the health care delivery system, it makes it difficult to plan appropriate interventions or disease management programs. You don't know what's missing [or] what's wrong with the data you're using," she says.

The on-line world amplifies privacy concerns, note experts. "HIPAA requires that when you handle patient information, you must have formal mechanisms for authorizing its use and disclosure and also be able to demonstrate how you protect the information," explains **Ann Geyer**, a health care information consultant with Tunitas Group Healthcare Consulting Practice in Moraga, CA. "You are required to ensure authenticity, but if the patient information enters your organization for

the first time via e-mail, you must rethink the ways in which you process patient information. The new state and proposed federal statutes don't offer a pass for e-mail. Every e-mail message in your organization can be a potential event that discloses patient information in violation of those privacy statutes."

Tunitas recently surveyed its clients and found that the average health care organization handles 50,000 e-mail messages each day, with 20% of

"On more than one occasion, personal patient information was sent to the wrong distribution list."

those messages going to external users and 80% remaining within the corporate boundaries. "For a large health plan, that number rises to about 75,000 messages a day. About 30% of those messages are thought to contain patient infor-

mation, and those communications carry a high degree of disclosure risk," Geyer says.

She cites two examples of potential Internet disclosure risks recently brought to her attention. The first involved a provider organization heavily oriented to behavioral and mental health services. The e-mail messages managed by this organization contained highly sensitive information about patient mental health issues, says Geyer. The organization had two e-mail distribution lists. The first list was a directory for the organization's tightly controlled review board. The second list was of the organization's record review staff. "On more than one occasion, personal patient information was sent to the wrong distribution list. Once you make an error of this nature via e-mail, you can't get it back," she cautions.

The second example also involved an e-mail directory problem. "The organization had confidential enrollment and third-quarter reimbursement data they sent to an outsider," she says. "The person had the same name and abbreviated organizational name as someone on the organization's

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financial staff. This is what makes the Internet so troublesome. E-mail directories don't always uniquely identify users. You can't differentiate between internal and external users, which makes access control a real concern. Normal network security principles are hard to apply to e-mail."

Although the final draft of the HIPAA regulations has not been issued, Myckowiak recommends that organizations take the following measures now to assure compliance:

- Monitor the progress of the final regulations.
- Understand your state privacy laws and those of every state in which you do business.
- Obtain a valid release signed by the patient specific to the particular type of disclosure for any information you disclose to other parties.

In addition, due to the high degree of disclosure risk involved with the use of e-mail, Geyer recommends that organizations develop e-mail policies protecting the privacy of patient information shared via Internet. "Without a written e-mail policy, your organization is running a huge risk of violating privacy statutes," she says. "As you sit down with your development team to think through e-mail policy, start with the recognition that e-mail protocols are not, by their very nature, secure. Most organizations are not very security conscious about e-mail issues. Developing an e-mail privacy policy and providing guidelines and expectations to all e-mail users in your organization about what they can and cannot put in an e-mail message is important for establishing privacy benchmarks."

Here is Geyer's four-stage plan for developing an e-mail policy:

- 1.** Treat e-mail as a business asset used only for business purposes in a businesslike manner.
- 2.** Recognize that e-mail is insecure and that no confidential information should be included in e-mail messages.
- 3.** Send confidential information via e-mail only when provided its confidentiality is protected by encryption.
- 4.** Recognize that health care business information is essentially protected information and that all disclosures should be authorized and recorded.

Your policy should clearly state who are the authorized senders and receivers of protected

information via e-mail, she adds. "You must also have a way to uniquely identify the senders and receivers. The problem is that current Internet mail protocols relay e-mail messages, and the senders and receivers have no control over how the messages are relayed. There is no way to check where a message came from or whether it was copied or altered en route from the sender to the receiver."

Even though the Internet mail protocols give you little to work with, it's still important to develop and apply a privacy policy to those areas that are within your control, says Geyer. Those areas include:

- Who in the organization is authorized to receive patient information via e-mail?
- What kind of patient information should never be sent via e-mail?
- What kind of information is readily adaptable to e-mail transmission?
- Where should a copy of e-mail messages containing protected patient information be sent for review?

"You should start with an exception policy — information that should never be sent via e-mail. You must also think symmetrically. In other words, review both how patient information leaves your organization via e-mail and how it enters your organization via e-mail."

Proceeding with caution

Questions she suggests you ask before sending patient information via the Internet include:

- Is the sender authorized to disclose the protected patient information?
- Is the receiver authorized to accept the protected patient information?
- What are the encryption procedures applied to the message?
- Was the information accurately received?
- Is a response to the message required?
- Is there a record of the disclosure?

Questions you should ask regarding patient information received via the Internet include:

- Is the receiver authorized to accept the patient information?
- Can the integrity of the information be verified?
- Is the sender a reliable source of the patient information?
- Who else will need to have access to the information?
- Is a response required?

Health care organizations also should be aware that employees will be tempted to violate even the best written and well-publicized e-mail privacy policies, cautions Geyer.

“There’s that ends-justifies-the-means mentality. Employees will weigh the risk of not submitting a report on deadline against the risk of potentially sending the report to the wrong individual. They have that ‘it-won’t-happen-to-me’ attitude. When it comes to a business risk assessment between getting the report in on time and a potential violation of privacy, getting the report in will win out. Violating the policy is seen as worth the risk,” she says.

Even health care organizations with established privacy policies should review them carefully to see if they meet the proposed HIPAA regulations, especially organizations that offer on-line health care services, notes Goldman. Here are key elements she suggests you look for in your current privacy policies:

- Does your policy adhere to basic principles of fair information practice as defined by HIPAA and applicable state statutes?
- Does your privacy practice adhere to your own privacy policy?
- Does your privacy policy provide users with anonymity?

“Providing anonymity is critical to closing the loop in that chain of trust between patients and payers and providers,” she says. “Individuals shouldn’t be forced to give up their privacy to use on-line services offered by your organization.”

Caring for patient X

David Levy, MD, chairman and chief executive officer of Franklin Health in Upper Saddle River, NJ, says patient anonymity is critical, and it’s not necessary to know whom you’re helping in order to provide on-line disease management support. “As a company that offers Internet-based and Internet-enabled products for the health care industry, we have created a technology structure that reflects our commitment to protecting the individual privacy of our customers’ beneficiaries.”

By virtue of their business, health plans have access to incredible amounts of data that enable patients to share control of their own care through the Web, notes Levy. “It’s the biggest opportunity in health care today, and the barriers to tapping into this opportunity are mostly related to privacy.”

Franklin Health’s Web site, personalpath.com, provides consumers with instant medical information customized to their health problems or needs. More important, says Levy, consumers can access that information with complete anonymity.

“The best way to ensure privacy is for the service provider to never know who the user is. No one should ever insist on knowing who you are in order to help you,” he explains.

Dividing the data

Franklin Health takes the patient information it receives from the large employer groups and health plans that are its customers and splits it into two strings. The first string contains personal information such as the patient’s name, Social Security number, address, and health plan identification information. The second string is everything known about the patient other than identification information. Both strings are given an anonymous identifier and then placed into two separate databases. The only thing the two strings have in common are the anonymous identifier, and the only individual to receive that number is the patient.

“The patient receives the anonymous identifier through the United States Postal Service. The identifier authenticates the user and allows them access to the site,” says Levy. “We’ve had health plans argue that they need information so that they can help their members. Maybe they have a diabetes management program and they want to know which members access information about diabetes on the Web site.

“We tell them no. Instead, we agree that we will inform the members about any disease management programs their health plan has that are appropriate for them and give the patient the right to choose to participate or not,” he says.

Providing patients with complete anonymity seems counterintuitive to most health plans and providers, notes Levy, adding that as uncomfortable as it may seem, it’s the only way to reduce patient anxiety about on-line health care services and gain their trust.

“We’ve had some very serious conversations about these issues with large health plans around the country,” he says. “We’ve held firm to the policy that we’ve raised ourselves to reach a very high threshold. We must meet that threshold or fall short of our mission.” ■

Summary of proposed HIPAA privacy rules

Will you be ready when final draft is issued?

(Editor's note: This article is adapted from several sources, including a summary on the Web site of the Health Privacy Project of the Institute for Health Care Research and Policy at Georgetown University in Washington, DC. The summary and interpretations of the rules by institute researchers can be accessed on the Web at www.healthprivacy.org.)

The 1996 Health Insurance Portability and Accountability Act (HIPAA) is a federal law designed to protect the privacy of patient medical records that are transmitted electronically. In October 1999, the Clinton administration issued a draft of its proposed HIPAA regulations and allowed for a 60-day comment period. More than 40,000 interested parties commented on the draft. Those comments are now being reviewed, and the federal government is expected to issue a final draft before the end of the year.

Here is a summary of the proposed HIPAA regulations:

- **Who is covered?**

- health plans;
- health care clearinghouses;
- health care providers who use computers to transmit health information.

- **What is protected?**

- information relating to a person's physical or mental health care or the payment of health care services;
- information that identifies or could be used to identify the person who is the subject of the information;
- information created by or received from a covered entity;
- information electronically maintained or transmitted by a covered entity.

- **What is a fair information practice?**

- Covered parties may only use or disclose the minimum amount of protected health information necessary to accomplish the intended purpose.
- Regulations provide incentives for covered parties to create and use health information that has been stripped of information that could be used to identify individuals, such as Social Security numbers and names.

- **What information can patients access?**

- Patients have a right to see and copy their own health information, including documentation of who has had access to that information.
- Patients can request amendments or corrections of health information that is incorrect or incomplete.
- Patients may not access their own health information when access would endanger the life or safety of another individual.

- **Who must be notified of privacy practices?**

- Covered parties are required to provide written notice of their privacy practices, including a description of an individual's rights in regard to protected health information, such as the individual's right to inspect and copy health records.
- Covered parties are required to provide written notice of the anticipated uses and disclosures of this information that may be made without the patient's written authorization.

- **When is patient authorization not required?**

- Covered parties and their business partners may use and disclose a patient's protected health information in order to obtain payment for services, authorize treatment, and for health care operations such as quality assessment, performance review, training programs, and audits.

- **When is patient authorization required?**

- Patient authorization is required for any purpose other than treatment, payment, and health care operations.
- Patient authorization must be voluntary.
- Covered parties may not condition treatment or payment on whether a patient authorizes release of protected information.
- Patients must be notified if the covered entity may profit from the use or disclosure of protected information.

- **What special rules address mental health records?**

- Separate voluntary authorization is required for the use and disclosure of psychotherapy notes.
- Patients cannot be refused psychiatric treatment, enrollment in a health plan, or payment of a claim for refusal to authorize disclosure of mental health information.

- **What information may be disclosed for judicial and administrative hearings?**

- Covered parties may disclose protected information in judicial and administrative hearings only if the request for information is made through or relates directly to a court order.
- This rule does not apply when information

requested relates to a party to the proceeding whose health condition is at issue.

• **Which public agencies may access protected information?**

— Covered parties may disclose protected information to public oversight agencies without individual authorization by patients for activities such as audits.

• **What special rights do minors have?**

— Individuals under the age of 18 who have the legal capacity to obtain health care on their own have the same rights as an adult with regard to their health information.

— Current state laws regarding parents and minors also apply. In states where parents have a legal right to access health care information, they retain that right.

• **What rules govern information used for research purposes?**

— Covered parties may disclose protected information without individual authorization only to researchers whose protocol has been reviewed and approved by a “privacy board.”

• **What rules govern information requested by law enforcement officials?**

— Covered parties may disclose protected information without individual authorization to law enforcement officials pursuant to a warrant, subpoena, or order issued by a judicial officer or grand jury.

— Covered parties may disclose protected information without individual authorization pursuant to an administrative subpoena or summons, civil investigative demand, or similar certification if the information is relevant, the request is specific, and de-identified information could not be reasonably used for the same purposes.

— Covered parties may disclose protected information without individual authorization for purposes of identifying a suspect, fugitive, material witness, or missing person.

— Covered parties may disclose protected information when the covered entity believes in good faith that the information relates to health care fraud.

• **What rules govern state public health laws?**

— Covered parties may disclose protected information for public health purposes as required by state laws, such as reporting of disease or injuries, collecting vital statistics, public health surveillance, and public health investigations or interventions.

• **What penalties may the government issue for HIPAA violations?**

— Civil monetary penalties of \$100 per violation up to a cap of \$25,000 annually may be levied against covered parties that fail to comply with the HIPAA rules.

— A criminal penalty of up to \$250,000 and 10 years in prison for information obtained under false pretenses or with the intent to sell the information for commercial advantage.

• **When can the HIPAA rules be preempted?**

— State laws that are more protective of individual privacy than HIPAA will stand.

— States may pass stronger laws in the future.

— HIPAA serves as a minimum baseline for privacy protections and allows states to maintain and enact stronger health information privacy laws.

(For information on what HIPAA means for Internet health care applications, see p. 93.) ■

Workers' comp/disability management

Legislation gives disabled right to self-direct care

Researchers will report outcomes to legislators

It took more than three years to get State House Bill 1880 passed in the state of Washington. Disability advocates say the bill, which passed in July 1999, is simply a civil rights law, but case managers with the state's Aging and Adult Services Administration in Olympia remain cautious, mostly out of concern for the safety of their clients.

The bill provides disabled individuals in the state of Washington the right to hire and self-direct an individual provider in their own homes to assist them with activities necessary to maintain their health, such as administering medications. “Individuals receiving Medicaid funding have not been able to do this before the bill was passed, and they were at risk of being put into a more restrictive environment,” notes **Patty McDonald**, program manager of the home and community services division of the Aging and Adult Services Administration.

Under the law, the person with the disability/client is responsible for the following:

- initiating self-direction by informing the

(Continued on page 103)



Reports From the Field™

Pulmonary care

Aggressive approach cuts antibiotic use

Improving outcomes for vent-related pneumonia

An invasive test that requires physicians to insert a bronchoscope into the respiratory tract may well be worth the risk and costs associated with the procedure, according to a recent study in the *Annals of Internal Medicine*. The test allows physicians to obtain fluid and tissue samples from the lungs of patients with suspected cases of ventilator-associated pneumonia.

Some pulmonologists have long advocated the use of invasive tests to diagnose suspected cases of ventilator-associated pneumonia. However, no studies have proven that the procedure improves patient outcomes.

Researchers studied 413 patients in 31 intensive care units in France with suspected cases of ventilator-associated pneumonia. Some patients received the invasive test, and others were diagnosed and treated on the basis of clinical findings alone. Researchers followed the patients to see who died or developed blood clotting or complications involving the heart, lungs, kidneys, nervous system, or liver. They also measured antibiotic use at 14 and 28 days.

After accounting for baseline differences in patients receiving the invasive test and patients not receiving the test, researchers found that patients who underwent invasive tests were less likely than those in the clinical findings group to

have died or suffered organ failure at 14 days. The advantage of using the invasive approach was less clear at 28 days, but the patients who had invasive tests still had better overall outcomes. For example, the invasive strategy group had fewer overall antibiotic days than the clinical findings group.

Researchers concluded that patients who undergo invasive tests to diagnose and manage suspected ventilator-associated pneumonia do better and spend fewer days taking antibiotics than patients in whom the diagnosis and management is guided by clinical findings.

[See: Fagon JY, Chastre J, Wolff M, et al. Invasive and noninvasive strategies for management of suspected ventilator-associated pneumonia: A randomized trial. *Ann Intern Med* 2000; 132:621-630.] ■

Diabetes

Exercise extends life for type 2 diabetes patients

Men with type 2 diabetes who do not exercise regularly are two times more likely to die than those with type 2 diabetes who are fit, according to a recent study in the *Annals of Internal Medicine*.

Researchers studied 1,263 men with type 2 diabetes who received a thorough medical examination between 1970 and 1993 who did not take insulin injections to control their diabetes. Study participants completed a medical history, questions about health and exercise

habits, a physical examination, blood tests, electrocardiography, and a maximal exercise test. Researchers classified study participants as “low fit” or “fit” based on their performance on the maximal exercise test. The 20% of the men who had the lowest fitness scores were classified “low fit” and all other participants were classified as “fit.”

Researchers used the national death index, a database that lists all deaths in the United States, to see which men had died by Dec. 31, 1994. Researchers identified 180 deaths among study participants for the period ending Dec. 31, 1994. After accounting for other risk factors, such as smoking and age, men in the low-fit group were two times more likely to have died than men who were in the fit group.

The study supports the idea that patients with type 2 diabetes should participate in regular exercise and improve their physical fitness. However, researchers note that only a study that randomly assigns participants to exercise or not exercise could prove this finding.

[See: Wei M, Gibbons LW, Kampert JB, et al. Low cardiorespiratory fitness and physical inactivity as predictors of mortality in men with type 2 diabetes. *Ann Intern Med* 2000; 132:605-611.] ▼

Combination therapy controls diabetes better

Study finds single agents don't control all causes

Most antidiabetic agents target only one of the underlying causes of diabetes. A new study suggests that a combination therapy using the drugs metformin hydrochloride and rosiglitazone maleate appears to maintain optimal glycemic control in patients with type 2 diabetes and offers better outcomes for patients whose diabetes is poorly controlled by metformin alone.

Researchers conducted a randomized, double-blind, placebo-controlled trial in 36 outpatient centers in the United States. The study included 348 patients between ages 40 and 80 with a mean fasting plasma glucose level of 12.0 mmol/L, a mean glycosylated hemoglobin level of 8.8%, and a mean body mass index of 30.1 kg/m².

Patients were randomly assigned to one of the following three groups:

- 116 patients received 2.5 g/d metformin plus placebo.

- 119 patients received 2.5 g/d metformin plus 4 mg/d of rosiglitazone.

- 113 patients received 2.5 g/d of metformin plus 8 mg/d of rosiglitazone.

Glycosylated hemoglobin levels, fasting plasma glucose levels, insulin sensitivity, and B-cell function improved significantly with metformin-rosiglitazone therapy in a dose-dependent manner.

Findings include the following:

- Glycosylated hemoglobin levels decreased by 1.0% in the 4 mg/d metformin group and by 1.2% in the 8 mg/d metformin group. Levels decreased by less than .001% in the placebo group.

- Fasting plasma glucose levels decreased by 2.2% mmol/L in the 4 mg/d metformin group and by 2.9% in the 8 mg/d metformin group. Levels decreased by less than .001% in the placebo group.

- Of patients in the 8 mg/d group, 28.1% achieved a glycosylated hemoglobin level of less than 7%.

Researchers concluded that combination therapy with once-daily metformin and rosiglitazone improves glycemic control, insulin sensitivity, and B-cell function more effectively than treatment with metformin alone.

[See: Fonseca V, Rosenstock J, Patwardhan R, Salzman A. Effect of metformin and rosiglitazone combination therapy in patients with type 2 diabetes mellitus. *JAMA* 2000; 283:1,695-1,702.] ■

Pain management

Study finds opioid use increasing in pain treatment

Researchers find no increase in opioid abuse

A retrospective study of six years worth of medical records published recently in *The Journal of the American Medical Association* found that opioid use to treat pain is increasing in the United States without any apparent increase in opioid abuse.

Researchers reviewed medical records from 1990 to 1996 stored in the databases of the Drug Abuse Warning Network and the Automation of Reports and Consolidated Orders system. They identified a nationally representative sample of

hospital emergency department admissions resulting from drug abuse. Researchers discovered that medical use of:

- morphine rose 59% from 2.2 million g in 1990 to 3.5 million g in 1996.
- fentanyl rose 1,168% from 3,263 g to 41,371 g.
- oxycodone rose 23% from 1.6 g to 2 g.
- hydromorphone rose 19% from 118,455 g to 141,325 g.
- meperidine declined 35% from 5.2 million g to 3.4 million g.

During the same period, researchers found the total number of drug abuse mentions per year due to opioid analgesics increased only 6.6% from 32,340 to 34,563. They found that reports of abuse of:

- meperidine decreased 39% from 1,335 g to 806 g.
- oxycodone decreased by 29% from 4,526 g to 3,190 g.
- fentanyl decreased 59% from 59 g to 24 g.
- hydromorphone decreased 15% from 718 g to 609 g.
- morphine increased by 3% from 838 g to 865 g.

Researchers concluded that the trend of increasing medical use of opioids to treat pain does not appear to contribute to increases in the health consequences of opioid abuse.

[See: Joranson DE, Ryan KM, Gilson AM, Dahl JL. Trends in medical use and abuse of opioid analgesics. *JAMA* 2000; 283:1,710-1,714.] ■

Managed care

Plan contracts force docs to manipulate rules

Study finds nearly 40% fudge bills

Health plan utilization rules appear to be forcing a large minority of physicians to employ strategic tactics to obtain coverage for patient services, according to a recent study report in *The Journal of the American Medical Association*.

Researchers mailed surveys to a random sample of 1,124 practicing physicians in 1998. Seven hundred and twenty physicians responded, for a response rate of 64%. Physicians were asked how often they had used one of three tactics in the past year to obtain reimbursement for patient services:

- exaggerating the severity of patients' conditions;
- changing patients' billing diagnoses;
- reporting signs or symptoms that patients did not have to help the patients secure coverage of needed care.

Thirty-nine percent of physicians reported using at least one of the listed tactics "sometimes" or more often in the past year. In multivariate models comparing that 39% to physicians who reported "never" or "rarely" using any of the listed tactics, researchers uncovered that physicians who use the tactics often are more likely to:

- believe that "gaming the system" is necessary to provide high-quality care;

- have received requests from patients to deceive insurers;
- feel pressed for time during patients' visits;
- have more than 25% of their patients covered by Medicaid.

In addition, of those physicians who reported using the tactics often, 54% reported doing so more often now than five years ago.

Researchers concluded that unless novel strategies are employed to address this issue, great utilization restrictions in the health care system are likely to increase physicians' use of "covert advocacy" tactics to obtain coverage for their patients.

[See: Wynia MK, Cummins DS, VanGeest JB, Wilson IB. Physician manipulation of reimbursement rules for patients. *JAMA* 2000; 283:1,858-1,865.] ■

Obstetrics

Home nurse visits yield lasting benefits

Nurses help reduce subsequent pregnancies

A home visitation program using nurses to improve maternal and child outcomes appears to significantly reduce subsequent pregnancies, increase the space between births, and decrease the number of months mothers spend on welfare, according to a recent study in *The Journal of the American Medical Association*.

Early discharge after MI appears safe

Extending hospital stays for uncomplicated acute myocardial infarction (MI) beyond three days appears to be unnecessary and economically undesirable, according to a recent study reported in *The New England Journal of Medicine*.

Researchers used data from the Global Utilization of Streptokinase and Tissue Plasminogen Activator for Occluded Coronary Arteries (GUSTO-1) trial to identify 22,361 patients with acute MI who had an uncomplicated course for 72 hours after thrombolysis.

Then, using a decision-analytic model, they examined the cost-effectiveness of an additional day of hospitalization in this group. Researchers defined incremental survival attributable to another day of monitored hospitalization, on the basis of rate of resuscitation after cardiac arrest between 72 hours and 96 hours. Lifetime survival curves for each group in the decision model were estimated from one-year survival data from GUSTO-1.

Improving the bottom line

Researchers found that of the 22,361 patients with an uncomplicated course within 72 hours after thrombolysis, 16 had ventricular arrhythmias during the next 24 hours. Of those 16, 13, or 81%, survived at least 24 hours. On average, another 0.006 year of life per patient could be saved by keeping patients with an uncomplicated course in the hospital another day. At a cost of \$624 for hospital and physicians' services, extending the hospital stay by another day would cost \$105,629 per year of life saved. In sensitivity analyses, researchers found that a fourth day in the hospital would be economically attractive only if its cost could be reduced by more than 50% or if a high-risk subgroup could be accurately identified in which the estimated survival benefit would be doubled.

[See: Newby LK, Eisenstein EL, Califf RM, et al. Cost effectiveness of early discharge after uncomplicated acute myocardial infarction. *N Engl J Med* 2000; 342:749-755.] ■

Researchers followed a group of 743 primarily black women for three years following the birth of their first child. The women were patients at an obstetrical clinic in Memphis, TN, who were enrolled in a home nurse visitation program for two years. Women in the study were fewer than 29 weeks pregnant, had no previous live births, and had at least two other sociodemographic risk factors, such as unmarried status, having fewer than 12 years of education or being unemployed.

Women received an average of seven home visits from a nurse during their pregnancies and an average of 26 visits from the time of birth until the child's second birthday. Outcomes of women who received home visitation were compared to a demographically similar group of women from the same clinic who did not receive home visits.

Home visits yield results

The study found that women who received home visits by nurses:

1. had fewer subsequent pregnancies — an average of 1.15 pregnancies, compared with an average of 1.34 pregnancies for the control group;
2. had fewer closely spaced pregnancies than women in the control group — an average of .22, compared with an average of .32 for the control group;
3. had longer intervals between the birth of their first and second child — an average of 30.25 months, compared with an average of 26.6 months for the control group;
4. spent fewer months receiving Aid to Families with Dependent Children — an average of 32.55 months, compared with 36.19 for the control group;
5. spent fewer months receiving food stamps — an average of 41.57 months, compared with 45.04 months for the control group.

[See: Kitzman H, Olds DL, Sidora K, et al. Enduring effects of nurse home visitation on maternal life course: A three-year follow-up of a randomized trial. *JAMA* 2000; 283:1,983-1,989.] ■

health care professional who has ordered the treatment;

- informing the case manager/social worker and providing verification of the treatment ordered for documentation purposes;
- developing the service plan in coordination with the case manager/social worker;
- giving the case manager/social worker the individual provider's name and other information for purposes of registration with the state;
- giving the individual provider a copy of the service plan and providing training for the tasks requested;
- supervising the performance of the individual provider;
- possessing the necessary knowledge and ability to train the individual provider to perform those tasks;
- asking for assistance in training, if necessary.

Case managers have expressed concerns about the potential for abuse and neglect and their own liability if abuse and neglect take place, notes McDonald. "Who may be held liable if a bad outcome occurs depends on a variety of issues. For example, if the physician prescribes an inappropriate treatment, the physician is liable. If the disabled person gives the care provider the wrong instructions, the disabled person is liable. If the care attendant refuses to follow directions, then the care attendant is liable."

Case managers who believe a self-directed client is at risk must document and make appropriate referrals; for example, to Adult Protective Services, says McDonald. "Case management is one of the most difficult jobs a person can undertake. The case manager is responsible for supporting the client, and that includes support in implementing the plan of care. If self-directed care tasks are not performed as outlined on the plan of care, the case manager may offer assistance or help the client obtain an alternative. Life is not black and white in the world of case management. Case management is often a series of shades of gray. A person with a disability does not have to self-direct. They also do not have to self-direct all of their needed care. For example, they could choose to self-direct their medications, but not their wound care. This is part of the service plan development process that the case manager and the client must work out."

Under the bill, the case manager is responsible for the following:

- identifying, along with the client, the self-directed care tasks;
- documenting the self-directed care tasks in the service plan and sharing them with the individual provider;
- registering and authorizing payment for the individual provider with the state;
- asking the client for verification of the prescribing health care practitioner's treatment order and document.

If a case manager is concerned about a client's ability to self-direct care based on cognitive deficits, the case manager may discuss the issue with the client's physician by having the client sign a release form and granting permission.

To add a degree of protection to disabled clients who choose self-direction, Washington requires that case managers run a background check for criminal convictions and substantiated claims of abuse or neglect on every individual provider hired by a disabled client, adds McDonald.

Give me liberty!

"It wasn't difficult for me to support the new bill. I see it as a civil rights issue for disabled individuals," says **Kathy Woods**, RN, BSN, lead manager of nurse delegation and nursing services with the Aging Adult Services Administration. "Lay caregivers have been performing some skilled nursing tasks for disabled individuals for some time. I think that in selected instances for persons willing to accept responsibility for their own care and who understand the risks, self-direction of care should be a private decision."

"There are so many activities we don't give a second thought — things like taking an aspirin or antibiotic as directed by our physician," notes **Mary E. McKnew**, a disability rights attorney in Olympia. "I have heard of numerous cases where a disabled individual was institutionalized because they were unable to have certain needs met in their own homes. The state system is built on the premise that we have to protect people with disabilities. That's a wrongheaded premise. We have to save that protection for those who really need it. We don't need to protect people who are intellectually capable of directing their own care but simply not physically able to carry it out."

The bill is designed to provide care options for individuals who fit that description. For example, a diabetic with a hand deformity may not be able

to administer daily insulin injections, notes Woods. "The individual may have been diabetic since birth and be very well-controlled and yet have this functional disability," she explains. "The individual doesn't have a family member or friend available to administer the injections, and third-party payers won't pay for daily home health care. If the patient wants to stay at home, now, under the self-directed care bill, they can teach someone else to inject their insulin. Too often, when you must turn to the state for funding, you lose your civil rights. The state gains the right to say what you can and can't do in your own home. This bill simply gives that right back to the individual."

Woods' support does not come without some degree of caution. "I'm concerned that disabled individuals who choose to self-direct their care may not always understand the consequences of incorrectly performed care," she says. "I don't believe this bill is appropriate for everyone."

The birth of the bill

The effort for self-directed care in the state of Washington started at about the same time discussions about nurse delegation were taking place, notes **Toby Olson**, executive secretary of the Washington State Governor's Committee on Disability Issues and Employment in Olympia. "I think individuals from the disability community were going to the hearings on nurse delegation, and they heard a great deal of discussion that didn't reflect the reality of their lives," he says. "They listened to debates about under which conditions a nurse could delegate authority to perform tasks to personal assistant providers, and that debate left out the person to whom those tasks were performed."

Those hearings on the nurse delegation legislation that passed in 1995 pushed the debate on self-directed care to the front, and public forums were held so the disabled community, state agencies, and health care professionals could share their concerns. At the same time, the state's department of health was able to fund a study of self-directed care initiatives passed in other states. The study was conducted by a graduate nursing student.

"It was very clear to everyone involved that the nursing student was very skeptical about the entire concept of self-directed care," says Olson. "I think it was very beneficial that she was so skeptical. Her literature search and her discussions with administrators in other states with

self-directed care legislation already in place turned her into a convert. I think her conversion made a strong impression on people who had some doubts about self-directed care."

Olson also credits face-to-face conversations between interested parties with helping the legislation pass. "Direct, unfiltered communication is very important. I think the life experiences that disabled individuals shared at those hearings were very eye-opening for many nurses. Nurses enter their profession to help others. I think the nurses involved in the hearings were shocked to find that many disabled people believe that the nursing profession in some instances was robbing them of their autonomy."

"As a health care professional," Woods says, "I want to make sure that people receive appropriate care, but that doesn't mean that I have to control the entire process. As a case manager, or a home health nurse, or a rehab nurse, I can educate the individual about the consequences of inadequate care. I have to educate them and allow them the ability to stay independent and take control of their own lives."

The state has contracted with two nurse researchers to evaluate the impact of the self-directed care bill. The researchers are mandated to evaluate the following five areas and present a report to state legislators by November 2001:

- consumer satisfaction with self-directed care, including consumer perceptions of degree of autonomy, self-direction, and choice allowed by the self-directed care bill;
- service quality and consumer safety as determined both by consumer and quantifiable outcomes such as hospitalization rates or nursing home placement;
- the number of reports that personal aides abused or neglected consumers;
- the number of consumer neglect or abuse cases that directly caused medical or social emergencies;
- whether the consumer has been coerced into accepting self-directed care or caregivers are coerced into performing tasks they are not trained to do.

The state took the same approach to the nurse delegation bill, using the same nurse researchers to conduct a study of the bill's impact. The nurse delegation bill allows nurses to delegate certain care tasks to unlicensed personnel trained and supervised by nurses in certain settings such as boarding houses.

"The state has taken a responsible and cautious

approach to moving ahead and making sure that the steps they take are appropriate,” says **Heather M. Young**, PhD, ARNP, FAAN, research associate professor with the school of nursing at the University of Washington in Seattle. “Not every older person needs to be protected. Not every disabled person needs to be protected. The state and health care professionals remain concerned, however, about how we can adequately protect the most vulnerable members of our society and still recognize the rights of persons with disabilities to be independent.”

Young found that the nurse delegation bill did not cause adverse outcomes, and due to the supervisory requirements, nursing involvement actually increased in some settings. “I think we found that in terms of personal care the outcome appears to be more dependent on whether the disabled person likes and trusts the caregiver rather than whether that caregiver is a nurse,” says Young. ■

Behavioral health

Guidelines ease confusion about drug treatments

Experts help you sort options for bipolar disorder

The overwhelming number of new pharmacologic treatment options for bipolar disorder made a revision of an earlier 1996 consensus guideline mandatory, say national experts on bipolar disorder. The experts participated in a consensus panel supported by Comprehensive NeuroScience in White Plains, NY, and unrestricted educational grants from nine pharmaceutical companies.

The new guidelines, “Medication Treatment of Bipolar Disorder 2000,” published in the April 2000 issue of *Postgraduate Medicine Special Report*, represent a consensus of 50 psychiatric experts. The guidelines are based on clinical experience as well as knowledge of the published data. They also help identify bipolar disorder by making the experience of psychiatrists available to physicians’ offices.

“On average, people with bipolar disorder see three to four physicians before they receive

a correct diagnosis,” says **Gary S. Sachs**, MD, director of Partners Bipolar Treatment Center at Massachusetts General Hospital and assistant professor of psychiatry at Harvard Medical School in Cambridge, MA. “One reason new guidelines will prove to be so useful is that once the correct diagnosis is made, appropriate treatment can be determined to better help patients manage their symptoms.”

“With these guidelines in their offices, all physicians will have useful information to help them make important diagnosis and treatment decisions. Years of experience are behind the guidelines, and physicians can rely on this tool to provide up-to-date information,” adds **John P. Dougherty**, MD, adjunct professor of psychiatry with the Weill Medical College at Cornell University in Ithaca, NY.

To develop the new guidelines, a survey based on peer-reviewed literature asked about more than 1,200 options for psychopharmacologic interventions in 48 specific clinical situations. The questions asked experts about appropriateness of treatment in situations using a scale of one to nine in which one equaled “extremely inappropriate” and nine equaled “extremely appropriate.” The broad range of treatment options included classes of medications, dosing tactics, and specific drug selection.

The survey was sent to national experts on bipolar disorder. The consensus panel used their responses to develop the guidelines, which include the following:

- Use a mood stabilizer in all treatment phases.
 - Divalproex sodium and lithium are the core choices for both acute and preventive treatment.
 - One of those mood stabilizers should be tried first when monotherapy is desired, in combination when either has failed, and as the foundation upon which other medications are layered.
- Mania or depression with rapid cycling should be treated initially with a mood stabilizer alone, preferably divalproex sodium, for either acute phase or prevention.
- Atypical antipsychotics, such as olanzapine and risperidone, are generally preferred to the older antipsychotics as adjunct therapy when a psychosis accompanies mania or depression.
- Mild depression should be treated with mood stabilizer monotherapy initially.
- Severe depression should be treated from the start with an antidepressant and a mood stabilizer.

The impact of bipolar disorder on families and friends can be devastating, note experts. Family

and friends are often uncertain about the nature of the illness and how to treat it. A small section within the guidelines, "Treatment of Bipolar Disorder: A Guide for Patients and Families," answers some of the most commonly asked questions about bipolar disorder in laymen's terms. This section explains symptoms, causes, treatments, and medications for bipolar disorder. Copies of this section can be obtained by contacting the National Alliance for the Mentally Ill (NAMI) in Arlington, VA, or the National Depressive and Manic-Depressive Association (NDMDA) in Chicago.

"Bipolar disorder is a serious, potentially fatal illness. Although effective treatments exist, there is an average lapse of eight years from onset of

symptoms to treatment. These guidelines will help physicians accurately diagnose the illness and meet the critical need for appropriate treatment," says **Lydia Lewis**, executive director of NDMDA.

The full texts of the guidelines and the patient and family guide are available on the Internet at www.psychguides.com. Reprints of the "Medication Treatment of Bipolar Disorder 2000" also are available by sending requests with a shipping and handling fee of \$5 per copy to: AdMail, 840 Access Road, Stratford, CT 06615. For pricing of bulk orders of 50 copies or more, call (914) 997-4008. For the patient and family guide, call NAMI at (800) 950-6264, or NDMDA at (800) 826-3632. ■

Disease management

Care improves when patients teach MDs

Program proves seeing leads to understanding

No one understands what it means to live with arthritis better than someone who wakes up and faces each day with this disabling condition affecting 40 million Americans. Patient Partners, an innovative arthritis education program sponsored by G.D. Searle in Skokie, IL, believes arthritis patients are the best instructors to help physicians understand what it means to live with arthritis.

"Health care professionals tell us the program has proven to be a powerful way to teach people about arthritis, whether they're medical students, established physicians, or patients," says **Carl Derinfeld**, MBA, CSW, senior director of the arthritis therapeutic team at Searle. "The Patient Partners are very helpful from an anatomy standpoint but also do an excellent job demonstrating to providers and patients the life implications of having arthritis."

"It's hard to describe the inflammation around the joint unless you show it," says **Lee Simon**, MD, medical director of the Patient Partners Program at Beth Israel Deaconess Medical Center/Harvard Medical School in Cambridge, MA. "We think this kind of teaching makes better medical professionals in the end. Our students

agree, often telling us that the Patient Partners sessions are among the best learning experiences they have had."

Simon says programs like Patient Partners fill a gap in traditional medical education. "In the past, students were taught the mechanics of the disease and its treatment. Patient Partner instructors help foster a better understanding about what it feels like to get up in the morning and not be able to tie your shoes or turn a doorknob," he notes. "Experience with Patient Partners can really sensitize doctors and help them realize that they are not just treating a collection of swollen joints."

You've got a friend

Patient Partners also are trained to help others with arthritis learn to cope with it. At community health education meetings, Patient Partners teach arthritis sufferers how to communicate more effectively with their providers. They also share information about improving quality of life, new devices, and treatment options.

The program began in 1992 with 350 Patient Partners recommended by their rheumatologists, says Derinfeld. Now, the program operates with roughly 200 Patient Partners, but Searle still asks physicians to recommend patients with these characteristics:

- **Diagnosed with rheumatoid arthritis.** "We have trained some Patient Partners with osteoarthritis, but most have rheumatoid arthritis," explains Derinfeld. "Rheumatoid arthritis patients present good diagnostic findings that make them good candidates for teaching physicians and medical students. In addition to interesting clinical findings,

they have major psychosocial events in their lives.”

- **Committed to making an investment in others.** “It’s a program that doesn’t pay a high stipend, so people have to be motivated to transfer their life experience to improving the lives of others with arthritis,” he says.

- **Demonstrate a desire for self-empowerment.** “We wanted to use patients with good self-care practices, who are actively partnering with their providers to take an active role in the management of their disease,” he explains.

- **Demonstrate good verbal skills and teaching ability.** “More than good verbal skills, we needed people with a presence,” he says. “These people had to be willing to stand up in front of groups of physicians and medical students and their peers and participate in a very rigorous program.”

As it moves into a new phase, the Patient Partners Program has become a regional model. “In the beginning, all the Patient Partners went through a training program developed and taught at the University of Texas Southwest in Dallas,” says Derinfeld. “Now, we’ve moved from a central training model to a regional model of training. We take the best and the brightest of the Patient Partners and teach them to train new Patient Partners. It’s going to make us much more efficient. We’re not going to have to send everyone to Texas for training anymore.”

Certified to teach

Patient Partners go through a rigorous training program, and they are required to be re-certified at specific intervals. The course covers:

- **Anatomy.** “The materials discuss the 80 trigger points for arthritis on a learning level equivalent to that received by a medical student,” notes Derinfeld. “After all, we expect [Patient Partners] to turn around and teach medical students and physicians how to perform a full body, hand, and wrist exam including all 80 trigger points.”

- **Psychosocial aspects.** “This covers many issues of the impact of the disease on all aspects of a patient’s life,” he says, such as work, social events, and recreational activities.

- **Management.** “This includes support, coping skills, and other nonpharmacological approaches to management, including diet and exercise,” he says. “The program is not branded to any particular drug, it’s branded to itself, so we discuss a wide range of treatment options.”

The program has three different audiences with three different teaching modules. “We are



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Editorial Questions

Questions or comments? Call **Lee Reinauer** at (404) 262-5460.

located in 10 teaching institutions. The program delivered in the hospitals is intended for everyone from second-year medical students to house staff," says Derinfeld.

The Patient Partners participate in a two-hour teaching curriculum. The director of rheumatology or the medical education director begins the program by delivering a 45-minute talk on rheumatology and arthritis. Then the medical students are divided into small groups. "The Patient Partner describes their life experience with rheumatoid arthritis and takes the students through an explanation of the full body exam. Then the student is asked to perform the exam with the Patient Partner acting as a coach and counseling them on how well they are doing," says Derinfeld. "For many medical students, this is their first hands-on experience with a patient."

Patient Partners also teach community-based providers to assess, understand, diagnose, and treat people with arthritis from a clinical and psychosocial standpoint. "This community program is less intensive and rigorous in its approach to the full body exam. We're dealing with experienced physicians here who don't need the attention to fine details that the medical students need," he says.

The final piece of the program is patients teaching other patients. "This is one of the areas the Patient Partners are most effective," he says. "They work with newly diagnosed patients or patients who have had the disease for a while but are still struggling to manage it."

Searle has collected quite a bit of information on the program over the past eight years. Many of the studies have centered around the professional training. "We know from pre- and post-program exams covering attitude and knowledge about arthritis that medical students clearly retain information and confidence after working with the Patient Partners," says Derinfeld. "Their knowledge of the disease increases consistently in the post-exam. On a qualitative basis, we also have heard repeatedly from medical students and practicing physicians that the program will play a major role in how they approach people with musculoskeletal disease."

(Editor's note: Case managers interested in the Patient Partners program can contact their local Searle representative or write to the Patient Partners Program, G.D. Searle & Company, 5200 Old Orchard Road, Skokie, IL 60077.) ■

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CE objectives

After reading this issue, continuing education participants will be able to:

1. List requirements of proposed medical record privacy regulations.
2. List issues to be included in an e-mail privacy policy.
3. List issues to be evaluated under new self-directed care legislation.
4. List key recommendations of new guidelines for treating bipolar disorder. ■

Resource Bank™

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

BSN degree available via Internet

A strategic partnership that will allow registered nurses to earn a bachelor of science degree (BSN) almost exclusively over the Internet was announced at the recent National Student Nurses Association conference in Salt Lake City. The new on-line degree program, BSN-LINC, was developed through a cooperative effort among the University of Wisconsin Learning Innovations, University of Wisconsin-Green Bay (UWGB), and NursingCenter.com.

Through the NursingCenter.com Web site, registered nurses can bundle access to continuing education courses and credits and the university registration fee at no increased cost. NursingCenter.com also will supply course packs with full text journal articles, as chosen by university faculty, to students in their customized electronic "file drawers," as well as a full range of searchable nursing reference materials.

The degree program is administered through the professional program in nursing at UWGB and is available to nurses in any state who have graduated with a 2.5 grade point average from an associate degree or nursing diploma program. The program is accredited by the National League for Nursing Accrediting Commission. Objectives and educational methods in the program are designed by UWGB to meet the needs of adult learners and practicing RNs.

"BSN-LINC provides tremendous flexibility for registered nurses because they can enter the program while still maintaining a full- or part-time schedule, which allows them to fit their study time around individual schedules, as well as to continue participating in other activities," says **Jane Muhl**, PhD, RN, associate professor and chairwoman of the professional program in nursing at UWGB.

For more information on BSN-LINC and the BSN degree program, visit NursingCenter.com or call (877) 656-1483. ▼

Pocket resource helps manage diseases in older patients

The American Geriatrics Society in New York City recently released the second edition of *Geriatrics At Your Fingertips*. This pocket-sized, comprehensive clinical guide is a useful tool for evaluating and managing the diseases and disorders that most commonly affect older persons.

The guide includes assessment instruments, recommended diagnostic tests, pharmacologic and nonpharmacologic management strategies, and updated federal rules useful for health care professionals treating patients in nursing homes.

The second edition is easier to use than the first and includes an expanded index and alphabetized chapters for easy reference. The revised edition also includes new information on peripheral vascular disease and neuropathies, findings from recent research, and updated information on the care of older adults.

The guide costs \$10.95 with discounts available for orders of 10 or more copies. To order, call (800) 338-8290. For bulk orders of 500 or more copies, call (800) 247-4779. ▼

Allergy report available on the Web

The American Academy of Allergy, Asthma, and Immunology (AAAAI) in San Diego recently released a 600-page report for primary care professionals on the diagnosis and treatment of chronic allergy conditions, which cost the health care system roughly \$10 billion annually, according to AAAAI.

The report was a two-year project in partnership with the National Institute of Allergy and Infectious Diseases in Bethesda, MD, and 20 medical and patient advocacy groups. "We are proud of this accomplishment," says **Gary S. Rachelefsky**, MD, task force co-chair and past president of AAAAI. "The report translates

knowledge into recommendations that family practice physicians, internists, pediatricians, nurse practitioners, physicians' assistants, and others who treat patients with allergies can use in their day-to-day practices."

The report is an evidence-based, practical, easy-to-access guide to allergic disorders. It includes standardized information on the most common allergic diseases and conditions that often have an allergic component. Conditions discussed include rhinitis, asthma, atopic dermatitis, rhino sinusitis, chronic or recurrent otitis media, conjunctivitis, hives, angioedema, contact dermatitis, and drug, food, insect sting, latex, anaphylactic, and anaphylactoid reactions.

The report is organized into three volumes, with references grouped by section for ease of use. It focuses on diagnosis and treatment as well as clinical recommendations and practical suggestions for specific conditions. It also addresses prevention, barriers to appropriate patient care, and the need for more allergy research.

The report is available on the Internet at www.TheAllergyReport.org or by contacting AAAAI at egrzegorek@aaaai.org. ▼

New tip sheet on medical errors

Background report also available

The Agency for Healthcare Research and Quality (AHRQ) has developed a new fact sheet with practical tips to help people protect themselves from errors in their health care. "20 Tips to Help Prevent Medical Errors" has specific, research-based recommendations on preventing medical errors related to medicines, hospital stays, and surgery. Other general recommendations to help prevent medical errors are also included.

To order the free one-page fact sheet, call AHRQ's publications clearinghouse at (800) 358-9295 and request publication #00-PO38. The tip sheet is also available on the Internet at www.ahrq.gov/consumer/20tips.htm.

AHRQ also recently released "Medical Errors: The Scope of the Problem," which includes statistics on the prevalence of medical errors, examples of medical errors, and research-based strategies for preventing medical errors.

To access the report, visit AHRQ's Web site at www.ahrq.gov/qual/errback.htm. ▼

Sweet news for diabetics

Health Care Products, a division of Hi-Tech Pharamcal in Amityville, NY, recently released DiabetiSweet "Measure for Measure," the first bulk sweetener that can completely replace sugar in baking and cooking. Diabeti-Sweet is more suitable than other sugar substitutes for baking and cooking because it tastes and cooks like natural sugar, according to the manufacturer.

Other sugar substitutes require the addition of some sugar in cooking and baking to maintain the quality standards of the recipe. Diabeti-Sweet eliminates that need because it is the only nonsugar bulk sweetener currently on the market with a one-to-one substitution rate for natural sugar.

DiabetiSweet contains no saccharin or aspartame and, according to the manufacturer, has the following characteristics:

- remains heat stable to maintain sweetness at high temperatures;
- is granulated for even consistency in baked goods;
- shares the same baking and cooking properties as sugar;
- has no aftertaste.

DiabetiSweet contains acesulfame k, a high-intensity sweetener, and Isomalt, a sweetener and bulking agent that adds volume to recipes and allows the sweetener to maintain sweetness in high heat. It contains no hidden forms of sugar like sorbitol or fructose, so it is safe for diabetics. In addition, it contains no sodium.

Diabetics can find DiabetiSweet in retail stores, including Wal-Mart, Kmart and Walgreens. More information is available on the Internet at www.diabeticproducts.com. ■

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. ■