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INSIDE

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Workers' comp/disability management

Is your patient's home or work environment causing a disability?

Here's how to help chemically sensitive patients remain productive

Many clinicians and employers remain skeptical about illness reactions reported by chemically sensitive patients. This skepticism surrounding multiple chemical sensitivity (MCS) often delays treatment and accommodation, leading to increased disability and delays in returning to work. Case managers must exercise their advocacy role in helping such patients receive the necessary modifications to their work and home environments. Those modifications, say clinicians and advocates, will minimize the exposures that prevent patients from being able to return to work.

What makes MCS such a hard sell for some payers, employers, and clinicians is that the symptoms of MCS are diverse and unique to each individual, says **Ann McCampbell**, MD, chair of the Multiple Chemical Sensitivity Task Force of New Mexico in Santa Fe. "The same chemical exposure may trigger different symptoms in different individuals. The unifying factor in people with MCS is that their symptoms come and go in relation to chemical exposures that do not ordinarily affect others."

(The wide range of symptoms and the way they disappear and return lead some clinicians to view MCS as a primarily psychological disorder. **For other views of MCS, see *Case Management Advisor*, April 2000, pp. 60, 65-68. For more on MCS diagnosis and accommodation, see stories in this issue on pp. 111-114.**)

The MCS phenomenon generally begins with an initiating exposure. Over time, the chemically sensitive individual reacts to more and more substances at lower exposure levels. Most patients can identify a specific exposure that appears to have initiated their illness; for example, a pesticide application or remodeling project. Once chronically ill,

patients experience a wide range of increasingly disabling health problems. McCampbell says the following are common symptoms of MCS:

- headache;
- fatigue;
- sleep disturbances;
- arthritis/joint pain;
- dizziness;
- poor coordination;
- heart palpitations;
- respiratory difficulties.

In addition, she notes that chemically sensitive patients may experience difficulty in concentrating, memory loss, learning problems, and aphasia after a problematic exposure.

"There is no one single test that can confirm a diagnosis of MCS. However, there are several guidelines for diagnosing MCS," McCampbell says. "In fact, the diagnosis of MCS is primarily a clinical diagnosis requiring no testing. The patient comes in and gives a typical history and course of illness. You basically confirm the diagnosis with response to therapy beginning with avoidance of chemicals. It's a matter of trial and error."

One useful tool in confirming a diagnosis of MCS is to ask patients to keep a journal, says McCampbell. "If the patient says, 'I think perfume makes me dizzy,' have the person keep a journal and record their response to different exposures. Are they fine on the weekend at home and then feel dizzy again when they return to work on Monday and are exposed to the perfume of coworkers?"

Testing to evaluate symptoms

In fact, physicians who specialize in treating the chemically sensitive say testing should be limited to evaluating specific symptoms. "I don't do a lot of testing unless there are symptoms that seem amenable to testing," notes **Michael B. Lax**, MD, MPH, medical director of the Central New York Occupational Health Clinical Center and associate professor of medicine at State University of New York Upstate Medical University in Syracuse.

"If the patient complains of shortness of breath, it may be useful to take a chest X-ray and perform a pulmonary function test," he advises. "There is no test that makes the diagnosis. Any testing that's done is only to make sure nothing else is going on that could explain some or all of the symptoms."

He adds that evaluating chemically sensitive patients is like evaluating any other patient. "If a chemically sensitive patient complains of chest pain, I work them up for heart disease like I would any other patient with chest pain. I use a traditional health approach to chemically sensitive patients beginning with a detailed job history. It's like playing detective — figuring out what the person has been exposed to and connecting it to the symptoms."

Several years ago, Lax and his colleagues reviewed the charts of the first 40 patients they treated for MCS. "We analyzed the cases for types of exposures that seem to be associated with onset of symptoms and the kinds of measures that seem to improve or worsen those symptoms," he says. "We found that many people are getting sick from preventable exposures."

The two most common preventable exposures in Lax's small study were construction and renovation projects and pesticide applications. "The most obvious thing we saw in this population was that construction and renovation of buildings that are occupied while the work is being done lead to illness," he notes. "We also found that when pesticides are applied in occupied buildings, people get sick. In fact, this is such a widespread problem that many schools and public agencies in New York are now using an integrated pest management program which eliminates the use of pesticides in buildings. I think these types of measures are reasonable in terms of trying to prevent this illness."

Limiting and preventing exposures when possible is definitely the best way to improve the health of chemically sensitive patients. However, McCampbell notes, there is a wide range of treatments that bring relief to some MCS patients. "Not all MCS patients are relieved by the same

treatments. What helps one MCS patient may have no effect or even worsen the condition of others," she explains.

Treatments McCampbell says have helped many MCS patients include:

- nutritional supplements given orally, intramuscularly, intravenously, or rectally;
- digestive aids;
- hormone supplementation, such as thyroid, adrenal, estrogen, progesterone, and melatonin;
- antidepressants;
- anticonvulsants;
- antiparasite treatments;
- supplemental oxygen;
- exercise;
- replacement of silver / mercury dental amalgams.

Call to arms

Case managers who step forward as advocates for chemically sensitive patients can mean the difference between employment and total disability and even homelessness, say MCS advocates.

"People who don't have this disease can't understand it. The minute someone admits they have this disease, anything else they say becomes suspect," notes **Susan Molloy**, MA, BA, a disability advocate who counsels MCS patients for an independent living center in Prescott Valley, AZ, and who has served on numerous state and national policy committees for MCS, including the National Coalition for the Chemically Injured.

"No one would ask a wheelchair-bound individual to explain why they can't walk up the steps to their house before funding a chair ramp," she says. "However, case managers are being asked to extract enormous amounts of medical, technical, and legal information to prove that many chemically sensitive individuals are disabled. In addition, payers don't cover the testing necessary to prove disability."

Molloy says case managers could improve the health and increase the productivity of their chemically sensitive patients by educating housing authorities, landlords, employers, and schools on how to make their indoor environments less toxic.

Case managers also can explain to employers and landlords that the accommodations necessary to make a living or working environment more comfortable for chemically sensitive patients often are relatively inexpensive, says **Mary Lamielle**, executive director of the National Center for Environmental Health Strategies in

Is your patient chemically sensitive?

Use this checklist to find out

Many chemically sensitive individuals suffer for years with a range of often disabling symptoms without making a connection between those symptoms and the environment, says **Ann McCampbell**, MD, chair of the Multiple Chemical Sensitivity Task Force of New Mexico in Santa Fe. Asking these questions may help you determine whether chemical sensitivity is present:

1. Do you hold your breath when walking down the detergent aisle in the supermarket, or avoid the aisle entirely, to keep from feeling sick?
2. Does the smell of perfume give you a headache or make you feel ill in some way?
3. Have you ever gone into a building such as a bank, supermarket, or discount store and felt disoriented or found that you had difficulty speaking, writing, or remembering things?
4. Have you ever suffered headaches or other symptoms at work or some other place, and later found that those headaches coincided with the spraying of pesticides?
5. Have you ever had an adverse reaction — such as headache, fatigue, respiratory problems, nausea, skin rash, or any other symptom — to a pesticide?
6. Do cleaning products or chemical deodorizers give you a headache or any other symptom?
7. Do you get a rash, headache, dizziness, or any other symptom when you are exposed to carbonless copy paper?
8. Do you hold your breath when entering a public restroom that's just been cleaned?
9. Do you feel better when you are away from your home, work, or some other environment that causes you to experience unpleasant symptoms such as headaches?
10. Are there foods you avoid because they make you feel ill?
11. Do you get headaches, eye irritation, feel disoriented, or have other symptoms when in a fabric or clothing store?
12. Do you get headaches, eye irritation, cough, or any other symptom when exposed to environmental tobacco smoke?
13. Does exposure to products or fumes in hair salons make you feel ill in any way?
14. Have you ever had an unusual reaction to a medication or drug?

Source: Multiple Chemical Sensitivity Task Force of New Mexico, P.O. Box 23079, Santa Fe, NM 87502. Telephone: (505) 983-9208.

Voorhees, NJ. "There was an insurance claims adjuster who became ill, and the accommodation that made it possible for him to return to work was a simple modification of the ventilation system and a request that his co-workers not use scented products," she says. "In addition, he was allowed to attend staff meetings and training sessions by speaker phone, or wear a mask. The total cost of the accommodation was $650. That is a doable thing."

Lamielle adds that sometimes just modifying a person's work schedule can mean the difference been productivity and disability. "For example, many buildings shut down their ventilation systems over the weekend or at night. Unfortunately, to make matters worse, this is the same time when many cleaning activities that cause reactions in the chemically sensitive take place," she notes. "Simply allowing employees to delay their return to work until the ventilation system is fully operational and the air has had time to clear can greatly eliminate illness."

Addressing the workplace

Patients sometimes can take action in their own behalf. Several employees in one public library in New York City became ill after exposure to certain cleaning products, notes Lamielle. "The employees made a list of less toxic cleaning products, bought samples, and tested them. They went to 200 employees in the building and asked whether the products would be acceptable to them. Then they went back to management and asked whether the cleaning staff could switch to the less toxic cleaner. Management agreed, and the problem was solved with no noticeable expense."

Unfortunately, once individuals are identified as chemically sensitive, they often face harassment from co-workers, adds Lamielle. "Case managers can educate employers and employees about MCS. Too many times, a well-meaning employer will ask employees to refrain from wearing perfume to work because 'it's making Bonnie sick.' This only serves to draw attention to Bonnie and [invite] both subtle and overt harassment."

Lamielle recalls one case where a guidance counselor was forbidden to open her window in order to improve the air quality in her office. "Not only that, but the window was nailed shut. We've also heard of cases of name calling and of chemically sensitive individuals having perfume sprayed in their faces in the workplace." ■

Helping employers create a healthier workplace

Simple modifications often are enough

Making a work or home environment more comfortable for chemically sensitive individuals is not as difficult as you may think. Case managers may want to share with employers these suggestions for creating a healthier work environment from the National Center for Environmental Health Strategies in Voorhees, NJ:

1. Design and construct buildings with windows that open.
2. Retrofit inoperable windows in existing buildings so they can be opened.
3. Keep the ventilation system functioning at optimum performance and free of contaminants.
4. Install and maintain localized exhaust systems to remove fumes from restrooms, cooking areas, and copy rooms.
5. Use building and personal air filters.
6. Locate fresh air intakes away from outdoor pollution sources. Close fresh air intakes or eliminate outdoor pollution sources if problems arise.
7. Maintain a smoke, fragrance, and pesticide-free environment.
8. Eliminate the routine use of air fresheners, deodorizers, disinfectants, potpourri, incense, and scented and pine-based products in buildings, ventilation systems, and mechanical dispensers.
9. Select the least toxic / allergenic building materials, furnishings, and supplies.
10. Arrange for cleaning, maintenance, pesticide application, construction, and remodeling activities, including painting, flooring, and roofing, to take place when the building is free of occupants. Ventilate any areas where such activity is taking place.
11. Prevent the growth of mold and other biologicals by regulating humidity, providing adequate ventilation, repairing leaks, and replacing water-damaged materials.
12. Provide advance notice of building events such as new construction, remodeling, pesticide application, floor waxing, and carpet shampooing, and provide alternative work space as necessary. Posting signs at all entrances and exits may help notify building occupants of upcoming activity.
13. Educate management and co-workers

regarding the need to maintain a pollution-free environment for the health of all building occupants. This effort should include information on chemical sensitivities and other environmental disabilities in order to create a positive attitude and prevent stigma and harassment.

[For more information, contact the National Center for Environmental Health Strategies, 1100 Rural Ave., Voorhees, NJ 08043. Telephone: (856) 429-5358. Web site: www.ncehs.org.] ■

Not sure what's making your patient sick?

Here's a list of common triggers

Chemically sensitive individuals often regain their health and productivity when their exposure to environmental contaminates is limited or eliminated. However, it's not always easy to determine exactly what exposure is triggering an individual's symptoms, says **Mary Lamielle**, executive director of the National Center for Environmental Health Strategies in Voorhees, NJ.

"It's important to narrow down the critical pieces by eliminating the most obvious contaminants first," explains Lamielle. "Once you've eliminated the obvious things, it becomes easier to identify the things that are left in the space which may be causing a chemically sensitive individual problems."

Here's a list of problematic environmental exposures that chemically sensitive individuals should attempt to avoid:

- **Pesticides:** insecticides, herbicides, and moth balls.
- **Petroleum products:** solvents, fuels, and natural gas / propane.
- **Plastics:** vinyl, latex, foam rubber, Styrofoam, and new electronic equipment with plastic-coated wires.
- **Outdoor air pollutants:** vehicle exhaust, industrial fumes, smog, tobacco, wood and charcoal smoke, and motor exhaust from mowers and other power tools.
- **Scented products:** perfume, cologne, shampoo, hair spray, hair gel, cosmetics, nail polish and nail polish remover, lotions, soap, detergents, fabric softener, air fresheners or deodorizers,

How to keep MCS patients safe in the hospital

Tips for avoiding complications

The average hospital stay holds many potential pitfalls for chemically sensitive patients. **Ann McCampbell**, MD, chair of the Multiple Chemical Sensitivity Task Force of New Mexico in Santa Fe, suggests case managers take these steps to limit triggers that could complicate the hospital stay — and delay discharge and recovery — of their patients with multiple chemical sensitivity.

1. Reassure your patient that you understand his or her chemical sensitivity.
2. Respect the patient's concerns and limits.
3. Make sure the chart is clearly flagged that the patient is chemically sensitive.
4. Consult with the patient's environmental physician, if possible.
5. Request that the patient be assigned to a private room with the following characteristics, if possible:
   - no pesticides, new paint, new carpet, or other recent remodeling;
   - no caregivers who wear perfume;
   - no caregivers who smoke;
   - no strong cleaners, scented products, or disinfectants.
6. Request that the patient be allowed to wear a mask or respirator.
7. Request that the patient be allowed to use an air filter and open windows as needed.
8. Request that the patient's door be kept closed.
9. Work with hospital case managers and staff to reduce the time the patient must spend in other parts of the hospital by performing as many procedures and evaluations in the patient's room as possible.
10. Request that the patient be allowed to use his or her own soap, clothing, and bedding whenever possible.
11. Provide hospital staff and the treating physician a list of the patient's history of drug reactions.
12. Request that the patient be administered IV fluids bottled in glass without dextrose.
13. Request that the patient receive medications in capsule form, when available, rather than tablet form.

[Editor's note: For sources of glass-bottled IV fluid, preservative-free medications, and other products suitable for chemically sensitive patients, call McCampbell at (505) 466-3622.] ■

MCS resources

The following resources may help you get your chemically sensitive patients the support necessary to return to work. However, **Ann McCampbell**, MD, chair of the Multiple Chemical Sensitivity Task Force of New Mexico in Santa Fe, cautions that the organizations and authors listed are not necessarily in agreement on the issues surrounding multiple chemical sensitivity (MCS). Case managers will have to help patients sort through the information to find the most applicable suggestions, she says.

Organizations

• **Human Ecology League**, P.O. Box 29629, Atlanta, GA 30359. Telephone: (404) 248-1898. Fax: (404) 248-0162. E-mail: HEALNatnl@aol.com. Provides patient support services and publishes a newsletter called *The Human Ecologist.*

• **National Center for Environmental Health Strategies**, 1100 Rural Ave., Voorhees, NJ 08048. Telephone: (856) 429-5358. Provides clearinghouse, educational, referral, support, and advocacy services for the public and those injured by chemical and environmental exposures. Also provides consulting services on access and accommodation issues.

• **MCS Referral & Resources**, 508 Westgate Road, Baltimore, MD 21229. Telephone: (410) 362-6400. Fax: (410) 362-6401. Web: www.mcsrr.org. Publishes *Recognition of Multiple Chemical Sensitivity.*

• **American Academy of Environmental Medicine**, 7701 E. Kellogg Drive, Suite 625, Wichita, KS 67207. Telephone: (316) 684-5500. Fax: (316) 684-5709. Professional organization of environmental medicine specialists.

• **Association of Occupational and Environmental Clinics**, 1010 Vermont Ave. N.W., Suite 513, Washington, DC 20005. Telephone: (202) 347-4976. Fax: (202) 347-4950. A professional organization for environmental health specialists.

Books and articles

• Ashford NA, Miller CS. *Chemical Exposures: Low Levels and High Stakes*. 2nd ed. New York City: Van Nostrand Reinhold; 1991. New York City: John Wiley & Sons; 1998.

• Hileman B. Multiple chemical sensitivity. *Chemical and Engineering News* 1991; 69:26-42.

• Radetsky P. *Allergic to the 20th Century*. Boston: Little, Brown and Company; 1997.

• Gorman C. *Less Toxic Alternatives*. DeKalb, TX: Optimum Publishing; 1997.

• Rapp DJ. *Is This Your Child's World?* New York: Bantam Books; 1996.

• Reed-Gibson P. *Multiple Chemical Sensitivity Survival Guide.* Oakland, CA: Harbinger Publications; 2000.

• U.S. Department of Health and Human Services, Public Health Service and Agency for Toxic Substances and Disease Registry. *Multiple Chemical Sensitivity: A Scientific Overview*. Princeton, NJ: Princeton Scientific Publishing Company; 1995.

• Miller CS. White paper: Chemical sensitivity: History and phenomenology. *Tox Ind Health* 1994; 10:253-276.

• Day N. Occupational hazards in the hospital, doctor's office and other health care facilities. *NC Med J* 1995; 56:189-195.

• Hayes JP, Fitzgerald MX. Occupational asthma among hospital health care personnel: A cause for concern? *Thorax* 1994; 49:198-200.

• Ziem GE. Multiple Chemical Sensitivity: Treatment and follow-up with avoidance and control of chemical exposures. *Tox Ind Health* 1992; 8:73-86. ■

incense, scented candles, and aromatherapy products.

• **Cleansers:** dry cleaning fumes; products containing chlorine, phenol, ammonia, pine; or other chemicals used to create scent.

• **Building products:** fresh paint, new plywood or particle board, tar fumes, glues and adhesives, new carpets, and veneered wood.

• **Fibers:** synthetic fabrics such as polyester and acrylics, fabric finishes such as products designed to make fabrics wrinkle-free, or make them stain- or water-resistant, and furniture upholstered in synthetic fabric or foam.

• **Printing/office products:** fresh ink from newspapers, magazines, and books; copy and fax machine fumes; computer printer fumes; felt tip markers; carbonless copy paper; new cardboard; glossy paper; and correction fluids.

[To order a copy of the booklet, "Multiple Chemical Sensitivity" by Ann McCampbell, MD, write to the Environmental Health Connection, 12 Bryce Court, Belmont, CA 94002. Or call McCampbell at (505) 466-3622.] ■

Reports From the Field™

New drug updates

FDA approves first new antibiotic in 35 years

The Food and Drug Administration recently approved the first new class of antibiotics in 35 years. Zyvox (linezoid injection, tablets, and oral suspension), from Pharmacia & Upjohn in Peapack, NJ, was approved for the treatment of gram-positive bacteria.

The new antibiotic is indicated for treatment of the following conditions in adults:

- hospital-acquired pneumonia;
- community-acquired pneumonia;
- complicated and uncomplicated skin and skin structure infections;
- vancomycin-resistant *Enterococcus* infections;
- complicated skin infections caused by methicillin-resistant *Staphylococcus aureus*;
- nosocomial pneumonia caused by methicillin-resistant *Staphylococcus aureus*;
- concurrent bacteremia associated with community-acquired pneumonia caused by penicillin-susceptible *Streptococcus pneumoniae.*

Clinical studies involving more than 4,000 patients treated primarily in the hospital have demonstrated that Zyvox is effective in treating infections caused by gram-positive bacteria, including some bacteria resistant to other antibiotics.

Zyvox belongs to a new class of antibiotics, the oxazolidinones. The drug attacks bacteria by stopping protein production at a very early point in the process that is different from any other currently approved antibiotic. Without protein production, bacteria cannot multiply, and they die quickly. ▼

Drug treats severe neuropathic pain

Roxane Laboratories in Columbus, OH, has announced the availability of Duraclon (clonidine HCI injection, 500 mg / mL), for the epidural treatment of severe pain in cancer patients that is not adequately relieved by opioid analgesics alone. The higher Duraclon concentration offers increased flexibility and convenience in treating cancer patients with severe neuropathic pain.

"While analgesia can be effectively managed with opioids in most cancer patients, those suffering from severe neuropathic pain often require more relief than opioids alone can provide," says **Stuart DuPen**, MD, associate director for pain research at Swedish Medical Center and clinical professor of anesthesiology and pain management at the University of Washington, both in Seattle.

"For these patients, Duraclon therapy offers an alternative to the invasive surgical procedures conventionally used to relieve hard-to-reach neuropathic pain," he says.

When used in combination with epidural opioids, Duraclon can be administered concomitantly with opioid analgesics for enhanced pain relief. In a clinical trial in cancer patients, Duraclon with epidural opioids provided significantly better analgesia than morphine alone: 45% compared with 21%. Duraclon with epidural morphine also provided relief to 56% of patients with

neuropathic pain, compared with 5% of those receiving morphine alone. Duraclon is not recommended for pain management in obstetrical, postpartum, or perioperative patients. ■

End-of-life care

Advance directives found to reduce utilization

Advance directives are commonly used in the community, but little is known about the effects of their implementation. Researchers studying the impact of advance directives found that they reduce health services utilization without reducing patient and family satisfaction or increasing mortality, according to a recent study in the *Journal of the American Medical Association.*

Researchers followed 1,292 residents in six Canadian nursing homes with more than 100 residents each. The "Let Me Decide" advanced directives program educated local hospital and nursing home staffs, residents, and their families about advance directives, offering competent residents (or next of kin for mentally incompetent residents) an advance directive that provided a range of health care choices for life-threatening illness, cardiac arrest, and nutrition issues. The six nursing homes were pair-matched on key characteristics, and one home per pair was randomized to take part in the "Let Me Decide" program.

Positive results

Of 527 participating residents in the intervention nursing homes, 49% of competent residents and 78% of families of incompetent residents completed advance directives. Findings include:

- Intervention nursing homes reported fewer hospitalizations — a mean of 0.27, compared with 0.48 for nonintervention nursing homes.
- Intervention nursing homes reported lower average total cost per patient — $3,490 Canadian vs. $5,239 CanadianCMA for the control homes.
- Intervention nursing homes reported a comparable proportion of deaths -— 24% in intervention homes vs. 28% in nonintervention homes.

[See: Molloy DW, Guyatt GH, Russo R, et al. Systematic implementation of an advance directive program in nursing homes: A randomized controlled trial. *JAMA* 2000; 283:1,437-1,444.] ■

Research roundup

News from the American Academy of Neurology

Multiple sclerosis (MS) patients benefit significantly from higher doses of beta interferon after four years of treatment, according to a study presented in San Diego at the recent 52nd annual Meeting of the American Academy of Neurology. The new long-term study provides additional hope for more than a million patients worldwide living with the continuing threat of disability due to relapsing-remitting MS.

The study began in 1994 and involved 560 patients at 22 centers in nine countries. Two-year data from the trial were published in 1998 in the British medical journal *The Lancet*. The data from that study demonstrated that both Rebif 3 × 22 mcg and Rebif 3 × 44 mcg per week significantly reduced the number and severity of relapses, delayed disability progression, and reduced disease activity and burden of disease as measured by magnetic resonance imaging. The new four-year data demonstrate that the higher dose of Rebif is statistically superior to the lower dose.

In evaluating patients at the four-year interval, researchers found that disease progression was most delayed in patients who started treatment two years earlier in the disease with the higher dose of Rebif, or 3 × 44 mcg per week, as compared with postponing treatment at the lower dose, or 3 × 22 mcg per week.

Rebif is not currently on the market in the United States due to Orphan Drug Law exclusivity for two other products. However, researchers are currently enrolling patients in a clinical study to directly compare interferon beta-1a doses across different product formulations.

The head-to-head trial will compare a 132 mcg weekly subcutaneous dose of Rebif to 30 mcg per week intramuscular doses of two other interferon beta products.

Rebif is manufactured by Ares-Serono in Geneva, Switzerland. Patients with MS interested in enrolling in the continued study of Rebif may call (888) 797-4477 or visit the World Wide Web at www.mspatient.com.

According to another study presented at the annual meeting, a drug used to treat some of the

symptoms of the sleeping disorder narcolepsy also appears to help control fatigue in patients with MS. Researchers found that a 200 mg/day dose of the drug modafinil, manufactured under the name Provigil by Cephalon in West Chester, PA, successfully controlled fatigue in patients with MS. "About 70% of MS patients suffer from fatigue," says **Kottil Rammohan**, MD, associate professor of neurology at Ohio State University. "It's one of the most disabling symptoms of MS."

During a nine-week trial, the researchers studied 72 patients with severe fatigue and MS. The patients received a placebo during the first two weeks and again during the final three weeks of the study. During weeks three and four, each patient received 200 mg of modafinil. During weeks five and six, the dosage was increased to 400 mg daily.

Evaluating side effects

After each phase of treatment, the researchers asked each patient to evaluate his or her level of fatigue and sleepiness. Overall, patients said they experienced significantly less fatigue when they took the 200 mg dose, compared with the placebo. However, when patients took the 400 mg dose, some of them experienced side effects that overshadowed the favorable effects of decreased fatigue.

In this study, the most common side effects were headaches, nervousness, and loss of physical strength.

In another study presented at the meeting, diabetic patients felt significant reduction in nighttime neuropathic pain after treatment with Memantine, a drug being developed in the United States by Neurobiological Technologies in Richmond, CA. The trial compared two dosage levels of Memantine, 20 mg and 40 mg, with placebo. In the 40 mg group, 44% of the patients experienced a 50% reduction in pain, compared with 29% of the placebo group patients. There was no significant difference between the 20 mg group and placebo, the study showed.

No drug has been approved by the Food and Drug Administration specifically for treatment of neuropathic pain. In addition to offering pain relief, note researchers, Memantine appears to have a more favorable safety profile than existing off-label treatments, which are primarily antidepressants. ▼

News from the American Urological Association

The largest controlled study of overactive bladder suggests patients taking an investigational once-daily capsule of the currently marketed Detrol (tolterodine tartrate tablets) produced by Pharmacia & Upjohn in Peapack, NJ, experienced significant improvement of all symptoms of the condition.

Researchers presented the findings of the 1,500-patient study at the 95th annual meeting of the American Urological Association recently in Atlanta. Patients in the study were treated with the investigational once-daily Detrol capsule, the currently marketed twice-daily Detrol formulation, or placebo. Patients reported the number of times they urinated, the volume of urine voided per bathroom visit, and the number of urge incontinence episodes periodically throughout the 12-week treatment period. Findings include:

- Significantly more patients taking the once-daily formulation of Detrol reported improvements in overall bladder condition than patients treated with placebo.
- Patients taking the once-daily formulation of Detrol reported a 71% improvement over placebo in reducing incontinence episodes per week.
- A larger proportion of once-daily patients reported improvement in urinary urgency, compared with placebo-treated patients.

Also reported at the annual meeting, results of a study of patients with prostate cancer suggest that the oral hormonal medication Casodex (bicalutamide, 150 mg tablets) shows no statistically significant difference in overall survival or time to progression when compared with surgical or medical castration in patients with nonmetastatic, locally advanced prostate cancer.

Researchers reported results from combined analysis of two studies of nonmetastatic, locally advanced prostate cancer; 480 patients were randomized to receive Casodex 150 mg once daily or castration. After a median follow-up of 6.3 years, there was no statistically significant difference in survival between the Casodex and castration groups. The difference in time to progression of disease also was not statistically significant. Casodex provided significant quality-of-life benefits over castration, including improved sexual interest and physical capacity. Casodex is manufactured by AstraZeneca in Wilmington, DE. ▼

News from the American College of Cardiology

Researchers have new evidence that a noninvasive test called Cardiolite can accurately predict the likelihood of a heart attack or cardiac death in patients with diabetes, according to a study presented at the recent American College of Cardiology meeting in Anaheim, CA.

In this multicenter study of 4,755 patients with known heart disease, researchers evaluated the role of Cardiolite in predicting heart attacks and cardiac death among 929 patients with diabetes. In addition, a subanalysis of 451 female patients with diabetes was conducted. Highlighting the findings, researchers concluded that the Cardiolite stress test successfully identified patients with diabetes at high or low risk for future heart attacks or cardiac deaths.

The researchers also found the test equally effective in predicting cardiac events in men and women. Notably, women with diabetes have considerably higher rates of heart attack and are more likely to suffer fatal heart attacks than are men with diabetes and nondiabetic women.

"What's particularly encouraging about the study results is that, by evaluating risk factors such as high blood pressure and high cholesterol, in combination with the information that Cardiolite imaging provides, we can identify the risk for heart attacks and cardiac death just as effectively in women as in men," explains **Leslee Shaw**, PhD, co-author of the study and associate professor of medicine at Emory University in Atlanta.

"Additionally, utilizing a test that performs equally well in women and men and in patients with and without diabetes makes it an extremely valuable tool in guiding cardiac treatment decisions," she says.

Cardiolite is the leading cardiac stress imaging agent in the Untied States. It is the only cardiac imaging agent approved by the Food and Drug Administration for the noninvasive evaluation of the heart's pumping ability and for gauging the amount of blood flow to the heart muscle itself. Cardiolite is manufactured by DuPont Pharmaceuticals in Wilmington, DE.

Another study at the annual meeting reported that chest pain patients can be assessed up to 75% faster with more frequent and rapid testing of cardiac markers. Investigators at the San Diego Veterans Administration Medical Center (SDVAMC) and the University of California at San Diego (UCSD) found that an accelerated chest management protocol using the Triage Cardiac System, a rapid diagnostic test manufactured by Biosite Diagnostics in San Diego, enabled patient assessment within 90 minutes and provided highly sensitive and specific means of managing chest pain patients. Additionally, 90% of low-risk patients were discharged before or at the 90-minute point with no adverse effects.

"Our study demonstrates that frequent, rapid testing of three key cardiac markers can enable physicians to make medical decisions regarding treatment, admission, and discharge earlier, which ultimately benefits the patient," says **Alan Maisel**, MD, professor of medicine at UCSD and director of the cardiac care unit at the SDVAMC. "This new capability may alleviate crowding in emergency rooms and critical care units, freeing up urgently needed medical resources for those patients who can best benefit from them."

Rapid diagnosis

A conventional heart attack diagnosis uses any two of these criteria: a positive electrocardiogram (ECG), patient history, and changes in measurements of cardiac markers, including proteins detected in the bloodstream to confirm the onset of a heart attack. The Triage Cardiac System simultaneously measures the levels of three protein markers — myoglobin, cardiospecific tropinin I, and creatinine kinase — in approximately 20 minutes, which is significantly faster than the one to two hours usually required for comparable laboratory work.

The UCSD/SDVAMC study included 1,285 consecutive patients who came to the emergency room with chest pain. The patients were evaluated according to a pathway, which involved frequent serial blood testing with the Triage Cardiac System in order to appropriately triage patients within 90 minutes.

"In combination with patient history and ECG changes, physicians using the rapid testing of three cardiac markers diagnosed all cases of myocardial infarction within 90 minutes of arriving in the emergency department with a sensitivity of 100% and specificity of 95%," says Maisel. "Additionally, use of the algorithm resulted in a 40% decrease in cardiac care unit bed utilization compared to previously used protocols. Of patients with normal ECGs and negative markers at 90 minutes, 90% were discharged." ■

Work site partnerships improve health

Patient satisfaction with managed care soars

American consumers generally are frustrated and dissatisfied with managed care, but one Utah health plan found that those feelings vanish when managed care plans partner with employers and bring health care to the workplace. In fact, the program has been so successful that the employer now pays the salary of the nurse case manager who runs the on-site clinic.

"If you're a managed care company, primary customers are employers. It makes sense to partner with your local employers to improve the health of their employees and your members," says **Jill Hoggard-Green**, RN, PhD, assistant vice president of clinical support systems for Intermountain Health Care (IHC) in Salt Lake City.

Becton Dickinson, a manufacturing company in Salt Lake City, came to IHC in the mid-1990s seeking ways to keep their employees healthy. "The company was very proactive," Hoggard-Green says. "Becton Dickinson realized that we have very low unemployment in our area, about 3%, and very low turnover. The company looked at its aging work force and realized that it had better keep that work force healthy to avoid heavy costs down the road."

IHC agreed to partner with the manufacturing company by bringing health services to the work site. "We really believed we could best improve the health of the employees by understanding how and where they worked and by making access to care as convenient as possible," she says. "However, we insisted that Becton Dickinson agree to our rules."

Those rules were:

- The program had to be voluntary.
- The data gathered had to be confidential.
- The health plan had to ask for and receive permission before sharing aggregate data.
- The employer had to agree that IHC would not share information about individual employees without specific consent.

Becton Dickinson agreed to all those conditions and provided clinical space at the manufacturing plant for IHC. "We've had an employee assistance program [EAP] on-site since 1993. We also have a physical therapy clinic on-site. It's a plant with a lot of hand injuries, so we have a therapist that specializes in hands. In 1996, we added a nurse case manager to the services we offered and also started distributing self-care books to employees," adds Hoggard-Green.

The nurse case manager's first responsibility was to conduct an annual health needs appraisal for employees. "The needs appraisal is a very short, 32-question tool with a regression formula which scores it. It's one way for us to . . . see that an employee is sick and go to work improving their health before they are hospitalized," she says. "It also has a health risk component that looks at health behaviors, such as smoking, so that we can design health promotion programs appropriate for the population."

Word of mouth

The first year, 350 of Becton Dickinson's 1,000 employees participated in the voluntary program. This year, 950 employees participated.

"I think a couple of things have driven that participation rate upward," notes Hoggard-Green. "First, during the first year the nurse case manager worked with a couple of employees who were in danger of losing their jobs because of health issues. They were diabetics who had trouble managing their care because they worked the night shift and couldn't regulate their insulin levels."

The nurse case manager, with the employees' permission, talked to the supervisor and had the employees moved to the day shift and their hours scheduled around their insulin schedules. Those employees started talking to their friends, and the staff began to see the benefit of working with the nurse case manager. After all, says Hoggard-Green, the service was free and confidential, and the benefit was visible.

Becton Dickinson also allowed staff paid time off from their jobs to attend health education and health promotion classes taught by the nurse case manager. "They get paid while they attend diabetes management classes. The employer is truly putting its money where its mouth is," she says.

The nurse case manager works with any employee who walks in the clinic. The primary services the nurse case manager provides are health assessment, education, coaching to encourage self-management skills, and coordination of care.

"The work site case manager can put a care plan together, and they are fiduciarily responsible for our health plan members," she notes. "The care plan the nurse case manager puts into the health plan computer becomes the authorized care plan. No one else can alter it. However, the nurse case manager is clinically and fiscally responsible for the care delivered to the employee. They follow the patients when they become patients in the hospital and wherever else they go in the health care delivery system."

In addition, the nurse case managers also do workers' compensation case management for the employees at their sites. "Employees who file a workers' comp claim are assessed by the EAP social worker and the nurse case manager. By working in tandem, a return-to-work plan is developed that addresses both medical and psychosocial issues. I'm a firm believer in blending those lines between mental health and medical care management," she notes.

Since the nurse case manager went on-site at Becton Dickinson in 1996, health appraisal scores have made a consistently upward turn. More important, a qualitative research study conducted by a nursing graduate student found that of 85 employees interviewed, not one would recommend discontinuing the program. "She interviewed 40 employees who had participated in the program and 40 who had not," Hoggard-Green says. "Overwhelmingly, they said the program had value. They also said that their health improved."

'Cost-neutral' program

At a time when most American consumers are complaining that managed care is denying them access to care, the Becton Dickinson employees said the nurse case manager program created better access to services. "Think of this on a national scale. Nationally, we have most Americans saying that managed care keeps us away from our doctors and provides us with less care. Here employees are saying just the opposite: that we've improved access to care and provided valuable education."

IHC found that the nurse case manager program decreased total medical costs at Becton Dickinson by about $300,000, says Hoggard-Green. After adjusting for the total costs of running the program, including the nurse case manager salary, researcher's time, and other resources, she says the program broke even. "What I have is a program that is cost-neutral. How many of you can say that your case management services are cost-neutral? We have fundamentally improved health at no cost."

The success of the Becton Dickinson program caused the employer to volunteer to pay the nurse case manager's salary just to make sure the program continues. In addition, other area employers have asked IHC to start similar programs at their work sites and have agreed to pay the nurse case manager's salary in order to bring the service to their employees. "Employers are winning here," Hoggard-Green says. "The program says, 'My employer cares about me.' When you have 3% unemployment, keeping your employees happy is very important." ■

Professional development

Are you meeting URAC's CM standards?

CM accreditation reviewer walks you through

If your organization hasn't yet applied for accreditation of its case management program through the American Accreditation Healthcare Commission / URAC in Washington, DC, consider this: URAC launched its accreditation program for utilization management organizations 10 years ago, and now 20 states have adopted or modeled their utilization management legislation after the URAC standards.

"When we develop standards, we're not just creating quality benchmarks, but we're defining the parameters of how case management organizations should function," notes **Gary Carneal**, JD, MA, president and chief executive officer of URAC. "Meeting accreditation standards today may help your organization meet state statute requirements tomorrow."

The case management organization accreditation was launched last year and initially received some criticism for being too stringent, especially in the areas defining qualifications for case managers and supervisors of case management, says **Sue Ohr**, MSHS, BSN, RN, RN-C, an accreditation reviewer for URAC's case management organization accreditation program. "The goal of case management accreditation is to set some nationally

recognized standards for the structure and practice of case management. We want to also raise the bar and ask organizations to continue to improve the quality of their services," she says.

The 33 case management standards are divided into 23 "shall" standards, which *must* be met, and 10 "should" standards, which organizations should strive to meet, Ohr says. Organizations must meet 100% of the "shall" standards and 60% of the "should" standards to receive full accreditation, she says, adding that most of the "should" standards center around the highly contested issue of case manager qualifications.

The standards are broken down into two general categories — structure and organization, and the case management process. As she travels around the country conducting accreditation reviews, Ohr notes common problems among case management organizations.

"We want to see that an organization has policies and procedures that govern all aspects of the case management process," says Ohr. "We want to see a well-written and developed mission statement. We want to see that there is clearly identified organizational oversight. We want to know that your case management definition is the same as URAC's. We also want to know who is responsible for the case management quality process."

"What we want to know is that you have a clearly identified number . . . you can evaluate that is based on a clearly defined rationale such as severity rating." — Sue Ohr, URAC reviewer

Specific elements that URAC requires case management organizations to identify include descriptions of the case management delivery model, telephonic or on-site; how the caseload is assigned; and the medical advisor.

"If I knew the best way to assign case management caseloads, I could retire from URAC," she says. "What we want to know is that you have a clearly identified number . . . you can evaluate that is based on a clearly defined rationale such as severity rating. We also want to see that you have an adequate number of staff members to care for your population."

URAC does not require case management organizations to have a full-time medical director, but it does require them to have a qualified clinician whom case managers can access when they have questions.

When the standards were first presented for review, case management staff qualifications were hotly disputed, Ohr says. The URAC standards were revised somewhat in response to public comment that they were too tough to meet. Currently, supervisors of case management must have at least a bachelor's degree in a health-related field, some type of licensure or certification in a clinical specialty, and at least five years of case management experience. In addition, the URAC standards require that if you have been a supervisor in an organization and held that position for at least three years, you should have a certification as a requirement of your job.

Creating lifelong learners

URAC requires case managers to have at least a bachelor's degree in a health-related field and licensure or certification in case management, or they must be an RN with at least three years of clinical experience.

Currently, URAC recognizes eight certifications as appropriate for case management. If you have a certification that is not on URAC's approved list, you can appeal, notes Ohr. "We invite you to provide certain information when you submit your application in order to have your certification recognized. To be recognized, a certification must be part of a validated and recognized program that is research-based. In addition, the certification must be at least partly based on passing an exam."

URAC also requires case management organizations to have a job description for case managers that identifies the qualifications expected, and an annual performance evaluation. "We also require organizations to have a full orientation process for staff and that they provide proof of the effectiveness of that training," says Ohr, adding that organizations also must provide ongoing and relevant professional education for staff.

"Some organizations we've accredited actually reimburse staff for license renewals and certification processes or certification prep courses," she says. "One best practice we identified was an organization that formed its own chapter of the Case Management Society of America in Little Rock and allowed staff to hold meetings on site during the lunch hour."

Two areas that cause problems for case management organizations during their accreditation

reviews are information management policies and procedures, she says. "We look at how you maintain patient confidentiality. We look closely at the care and storage of your records. Are you shredding your records after seven years, or do you contract with a vendor who disposes of old records properly?"

URAC also requires organizations to have a policy regarding the ethical use of patient data. "We want to know that data is used in the aggregate for outcomes measurement," she explains.

Although the standards require organizations to have a grievance process and track the grievances, she encourages case management organizations to track their compliments as well. Potential clients often ask about past customer complaints. "Wouldn't it be nice to say, 'I have that information, but I also have information on the number and types of compliments our staff has received.' It's a wonderful way to market your services," she notes.

Measuring effectiveness

URAC requires case management organizations to have a quality improvement process that evaluates the effectiveness of an organization's case management services. Measures URAC looks for during accreditation reviews include disease management outcomes, cost-savings outcomes, utilization of resources, availability of care, effectiveness of preventive care, and cost of care.

Oversight of delegated functions and disclosure of information to patients regarding the case management services also have caused problems during the review process. "If you subcontract any of your services, you must have a written contract with subcontractors, perform periodic review of their policies and procedures, and monitor their performance," Ohr notes.

However, the standard that most organizations have trouble implementing is the disclosure of information standard, says Ohr. "Usually, when I do a desktop review, most organizations state they have a policy for disclosing information about their services to patients, but when we go on site and evaluate, we find there's no documentation to support that statement."

URAC requires patients to be informed at the onset of case management services about the nature of the case management relationship. "As a best practice, what I've seen work best is a letter of introduction that is sent to the patient prior to case management service. If, as an organization, you don't feel that a letter of introduction will work for you, you must have a system for documenting verbal disclosures."

Information Ohr says must be disclosed to the patient includes the circumstances in which you will release information to third-party payers; how and when the patient will receive written notification of the care plan; the complaint process; and the rationale for the case management service, or why the patient was selected for case management. Of course, URAC also requires organizations to receive consent from patients before beginning case management services. "We want to see documentation of the patient's oral consent to case management services and a preference for receiving written consent," she says. "That consent must be explicit."

Another area that seems to cause problems for case management organizations is the plan of care standard, she says. "We find [that] many organizations fail to meet the full standard. You must have a short-term and a long-term goal and time frames for response to your interventions. You have to identify which resources you are going to use. You also have to clearly establish the criteria for case closure." In addition, there must be a written policy for conflict resolution. "Do you know how you are going to resolve differences, if the supervisor disagrees with the case manager's care plan?" Ohr says.

One of URAC's goals is to establish that case management remain patient-centered. "We look closely at patient access to care," says Ohr. Questions you may be asked by a reviewer include these:

- Do you have a toll-free number?
- Do you have a collect call system?
- Do you have a process in place for timely call backs?

"Our objective is to evaluate the program's ability to deliver high-quality services. It's a way to identify for purchasers of case management services that your organization has met a published set of standards and to state and federal regulators that your organization promotes outcomes measures and management through accountability," says Ohr.

[For additional information, including a list of accepted certifications, contact: American Accreditation Healthcare Association/URAC, 1275 K. St. N.W., Suite 1100, Washington, DC 20005. Telephone: (202) 216-9010. Fax: (202) 216-9006. Web site: www.urac.org.] ■

CM finds its way into state/federal laws

Survey: More than 2,000 statutes refer to CM

In preparation for the launch of its case management program accreditation last year, the American Accreditation Healthcare Commission / URAC in Washington, DC, took a close look at how case management is regulated at both the state and federal levels. It found references to case management in statutes in all 50 states — more than 2,000 references, to be exact, according to **Gary Carneal**, JD, MA, president and chief executive officer of URAC.

"We did a search using LEXIS-NEXIS, a computer search tool used for legal research, and drilled it down and focused on the health application of case management by using three key terms — insurance, health, and medical — along with the terms 'case management,' 'case manager,' or 'care management,' and found that these terms are used frequently within state regulation," he explains.

Carneal updated his search this April with the following results:

- 2,102 state statues refer to case management.
- 840 state statutes refer to care management.
- 377 state statutes refer to case manager.
- 3,123 state statutes refer to at least one case management term.
- 1,337 state statutes refer to case management and either insurance, health, or medical.
- 282 state statutes refer to care management and either insurance, health, or medical.
- 296 state statutes refer to case manager and either insurance, health, or medical.
- 1,756 state statutes refer to at least one case management term and either insurance, health, or medical.

In addition, Carneal says case management is referred to 179 times in state workers' compensation codes and 569 times in state disability statutes.

"When you begin to aggregate this on the state level, you can see that every state has at least one reference to the term 'case management.' Does this mean more regulation of the case management profession is coming? Perhaps not, but certainly these statutes impact how you get funding and how you spend your time as a case manager," he says.

As he looked at the state statutes, Carneal was able to draw the following four conclusions:

- Most case management laws are oriented to social service and public welfare issues.
- There is no enabling legislation for case management organizations similar to legislation for health maintenance organizations or utilization management organizations.
- A typical reference to case management is a simple identification of case management as covered or not covered by a particular program.
- Most state statutes that refer to case management do not address health benefit issues directly.

On the federal level, Carneal found 125 statutes that refer to case management and either insurance, health, or medical. Those statutes also seem to fall primarily in the areas of social service or public welfare programs. Federal programs with statutes or codes referring to case management include the food stamp program, immigration (refugee assistance), medical and dental care

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Editor: **Lauren Hoffmann**, (770) 955-9252, Fax: (770) 956-1781.
Vice President/Group Publisher: **Donald R. Johnston**, (404) 262-5439, (don.johnston@medec.com).
Managing Editor: **Lee Reinauer**, (404) 262-5460, (lee.reinauer@medec.com).
Senior Production Editor: **Terri McIntosh**.

Editorial Questions

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

for the armed forces, Indian health care, veterans' benefits, housing assistance, foster care and adoptive services, medical assistance and Social Security provisions, and child mental health and abuse prevention.

Perhaps even more revealing is that Carneal found 2,405 federal and state court decisions that refer to case management and either insurance, health, or medical.

"Further searching narrow[ed] that figure down dramatically to 12 cases where 'case management' or 'case manager' is a core term," he says.

Court decisions indirectly regulate care

Carneal explains that case law can establish principles that affect how case managers do business. For example, one ruling came out of a workers' compensation appeals panel in Tennessee. In that case, an injured employee had a work-related low-back injury and went to his physician for treatment.

"The payer was not clear that the employee was seeking treatment specifically for the work-related low-back injury and deauthorized the original physician and assigned the employee a new physician," he says. "The appeals panel looked at the workers' compensation statute and ruled that a workers' comp carrier is not allowed to deauthorize a physician without just cause and pointed out the injured employee should not bear the burden of establishing reasonableness of care. Clearly, this is an area where the case manager might be expected to be involved."

In Minnesota, a young man with Tourette's syndrome and depression sought state disability services, specifically case management education and support services, under a state statute designed for individuals with mental retardation. "The court ruled that the state had to extend case management services based on the facts of the case. What is important here is that courts are sometimes used to decide whether case management services are provided," says Carneal.

"In this way, court decisions are an indirect way in which case management services are regulated," he explains. "This is where accreditation processes can step in and provide case management organizations with a set of rules and guidelines for how to operate." **(For a step-by-step guide through the URAC accreditation process, see p. 120. For more discussion on how to sail through accreditation, see *Case Management Advisor,* December 1999, pp. 181-184.)** ■

CE objectives

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

1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how those issues affect case managers and clients.
3. Describe practical ways to solve problems that nurses commonly encounter in their daily case management activities. ■

Resource Bank™

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

What's new on the Web: Helpful sites for CMs, patients

New health care Web sites appear regularly on the Internet. Here are four newly launched sites that may be useful to case managers and their patients:

• **www.onconurse.com** is a new, not-for-profit Web site that provides free fact sheets case managers can download and share with patients. Available topics include:

— advanced breast cancer;
— living with ostomy;
— clinical trial resources;
— childhood cancer and school;
— late effects of childhood cancer treatment;
— dealing with managed care;
— what leukemia is;
— what are non-Hodgkin's lymphomas?;
— patient rights and responsibilities.

• **www.medtronic.com/traveling.** Not knowing where to go in the event of a cardiac problem when traveling causes considerable concern for people with implanted heart devices. Now, by simply logging on to any computer with Internet access, people with implanted devices that carry the Medtronic or Vitatron brand name can obtain information about specialty care centers in or near their travel destinations. Clinicians at the listed centers can evaluate the patient's condition and are equipped with the necessary programming devices to adjust pacemakers and defibrillators as needed.

In the United States, patients can log onto the Internet and select a state and city or zip code to obtain a list of physicians and centers in the area familiar with their devices, along with contact information. Outside the United States, patients can select one of 120 countries worldwide and obtain contact information for centers qualified to assist them.

In addition, the site contains answers to frequently asked questions and other important information about traveling with cardiac rhythm management devices. The site is a free service provided by Medtronic, a manufacturer of implantable pacemakers and defibrillators based in Minneapolis.

• **www.creakyjoints.com** is a sometimes irreverent, often humorous, and always very personal Web site for the 42 million Americans with arthritis. It was launched by Seth Ginsberg, a 19-year-old college freshman at Babson College in Wellesley, MA.

The site contains testimonials from arthritis sufferers, including Ginsberg himself, contributing writers of all ages, and a fictional arthritic dog named Creak. It also contains features to which site visitors can contribute, including drug interactions and side effects and comments on over-the-counter drugs.

• **www.depression-screening.org** was developed by the National Mental Health Association in Alexandria, VA, to allow individuals to take a confidential screening test on-line for depression, as well as find a reliable source of information on the illness.

The depression screening test provided on the Web site is the HANDS Screening Tool, a 10-question scale developed by Screening for Mental Health in collaboration with the Harvard Medical School department of psychiatry in Cambridge, MA. The tool has been validated for detecting the likelihood of clinical depression.

Test results and recommendations

After completing the on-line test, visitors to the site receive their results and recommendations indicating the probability of depression and whether further evaluation by a health care professional is recommended. Results of the test are anonymous and confidential. The site urges visitors to print their test results and share them with their health care providers to initiate dialog about the need for further testing, evaluation, and possible treatment options.

The site also includes a directory of health care professionals nationwide who provide free one-on-one depression screening, as well as referrals to local mental health professionals. ▼

Fraud, abuse kit helps docs comply with federal programs

The Pennsylvania Medical Society in Harrisburg unveiled its "Fraud and Abuse Prevention Kit" to help physicians and other health care providers who participate in Medicare and Medicaid programs comply with the laws and regulations that govern those programs.

The kit provides insight into the guidelines that cover documentation, coding, and billing processes. Physicians who are members of the Pennsylvania Medical Society may obtain the kit by contacting Patricia Bucek at (717) 558-7750. Nonmembers should contact Mike Berk at (717) 558-7750, ext. 1420. Berk can also be reached via e-mail: mberk@pamedsoc.org. ▼

There's no place like home

Home-based employees, whether they telecommute or are self-employed, face hazards in their daily routines that may cause injury. To meet the needs of this quickly growing segment of the work force, the American Industrial Hygiene Association in Fairfax, VA, has developed a free brochure, "There's No Place Like Home . . . For Workplace Safety."

The brochure covers a range of topics from indoor air quality to choosing the correct computer chair. The publication is designed to help consumers stay as safe and healthy as possible when they work from home.

To order, call (703) 849-8888 or visit the organization's Web site at www.aiha.org. ▼

Help ease kids through bone marrow transplants

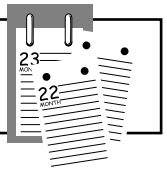
Bone marrow transplants are complicated and often overwhelming for pediatric patients and their families. A new book, *Me and My Marrow,* attempts to guide children through the difficult procedure.

The book was inspired and co-written by Cristina Cuzzone, a young leukemia patient who told her story to professionals at Fujisawa Healthcare, a pharmaceutical company in Deerfield, IL. *Me and My Marrow* explains what a transplant is, how it is done, what treatment will feel like, and how to cope with difficult times. The easy-to-read book is filled with colorful illustrations that help tell Cuzzone's story. Serving as a guide, Cuzzone shares her own experience along with practical advice from other children who have undergone bone marrow transplants.

The book covers everything from coping with physical change to resuming old friendships at school. It is divided into three main sections: before, during, and after a transplant.

Copies of *Me and My Marrow* have been distributed to transplant centers nationwide. In addition, an interactive version is available on the Internet at www.meandmymarrow.com. The site posts stories and advice from pediatric patients about their bone marrow transplant experiences. The site also suggests videos, books, newsletters, and other Web sites that might be helpful to patients and their families. ▼

CALENDAR



• **Sept. 23-27.** Manifesting Our Destiny: Fulfilling Our Dreams: The 19th Annual Meeting and Home Care Exposition of the National Association for Home Care (NAHC). Held at the Ernest N. Morial Convention Center in New Orleans. Sponsored by NAHC in Washington, DC. Telephone: (202) 547-7424. Fax: (202) 547-3540.

• **Sept. 25-27.** The fifth annual Disease Management Congress and Exposition. Held at the Hynes Convention Center in Boston. Sponsored by the National Managed Health Care Congress in Waltham, MA. Telephone: (888) 882-2500. Fax: (941) 365-0157. E-mail: register@nmhcc.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. ■