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INSIDE

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Sweeping HIPAA regulations call for big changes in your office

Take steps now to make sure all bases are covered

Do you routinely leave patient files on your desk? Do you sometimes discuss patients with your colleagues on the telephone within earshot of anyone passing by your office? Is your fax machine out in the open, where anyone can see what is being faxed in? Do you discuss the medical condition of patients with their family members or other primary caregivers?

Any of these everyday scenarios could get you in hot water with the government when the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations go into effect. **(For information on how HIPAA came about and where it is headed, see story, p. 125.)**

Basically, to comply with HIPAA, virtually everyone in the health care industry will have to overhaul their methods of handling and transmitting medical records. HIPAA regulations cover health plans, health care clearinghouses, and health care providers who conduct financial and administrative transactions electronically.

Don't think that because you're a case manager working for a larger entity you should ignore HIPAA and its implications for the way you conduct business.

"HIPAA is a sleeping giant for most clinicians, including case managers," says **David Kibbe**, MD, MBA, chief executive officer of Canopy Systems in Chapel Hill, NC. "Case managers don't necessarily have to become experts, but they should be informed."

Case managers should familiarize themselves with HIPAA regulations, take steps to ensure they will be in compliance, and make sure they are represented on their employers' compliance committees, experts advise.

Payer organizations, providers, and hospitals — anyone who handles patient-specific health care information — will have to come up with policies and procedures for complying with HIPAA regulations.

If you work for a large organization, you probably are assuming that other people will take care of a lot of the details of HIPAA compliance.

But case managers should get involved in their organization's HIPAA compliance activities to make sure their voice is heard, Kibbe asserts.

Kibbe suggests that case managers volunteer to sit on HIPAA compliance teams that will set up policies, procedures, training, and information system modification.

It might be easy to think that your security officer or information technology staff will take care of all the HIPAA details, but you might find yourself in the position of having to carry your files with you at all times or to make a paper record every time you access the computer to stay in compliance with your organization's policies.

"Case managers should become part of the team," says Kibbe. "Otherwise, they may find that they are subject to onerous regulations set out by someone who doesn't understand their job."

In addition, case managers should be certain that their employer's policies allow them the access they need to patient information, adds **Janice Cunningham**, an attorney with The Health Care Group, a Plymouth Meeting, PA-based health care consulting firm.

Communicating health care information is essential to the case manager's job. You have access to and frequently share patients' identifiable health care information, and you should make sure that your organization's compliance plan isn't going to be a hardship on you.

"Case managers need access to clinical records, to billing and payment records, registration information, demographics — they need to see it all," notes Cunningham.

However, one concept in privacy regulations is that staff will be given access to the "minimum necessary" amount of information needed to do their job. If case managers aren't given full access to patient information under their employer's policies and procedures, it could affect their ability to do their job, Cunningham points out.

So far, three sets of HIPAA regulations have been proposed: transaction standards, privacy standards, and security standards. **(For details, see chart, p. 123.)** Final rules have been issued for transaction and privacy standards.

Most case managers don't have to worry much about the transaction standards because their information technology department will be responsible for implementing the changes.

Security/privacy regs are key

However, the security and privacy regulations will have a big effect on case managers' activities. "Case managers manipulate and handle information in a lot of ways that probably don't meet HIPAA privacy or security regulations," says Kibbe.

Look at anything you do that involves the security and privacy of a patient's identifiable health care information. That's sure to be affected by HIPAA, points out **Pat Orchard**, CCM, CHE, assistant vice president of Virtua Health in Voorhees, NJ.

In addition to looking at electronic and web-based systems, case managers should increase their awareness of how they handle paper documents, Orchard says.

"Independent case managers need to be well aware of HIPAA regulations for their own security and the security of their business. But case managers who work for large institutions should be just as aware of the privacy issue. In a large institution, you have access to more information, and this allows you more liability," Orchard says.

Here are some other steps that will help you prepare for HIPAA:

- Familiarize yourself with HIPAA regulations, particularly those that will affect your practice.
- Look at all the processes you handle that involve patient confidentiality, privacy, or security of the system.
- Do a thorough assessment of your current practices for handling patient information.
- Consider moving from paper records to electronic records.

"It is important for case managers to understand that their organization is under a lot of

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pressure to comply with HIPAA, and the only way to assure compliance is for case managers to move more of what they do into electronic formats," Kibbe says.

• Don't assume that because you're not using an electronic system you're OK. The regulations cover all information, whether written, electronic, or oral. ■

HIPAA standards to date: What you need to know

The Health Insurance Portability and Accountability Act (HIPAA) eventually will include seven sets of regulations. So far, three have been released:

• **Transaction standards**, which set out standardized ways that patient health, administrative, and financial data can be transmitted. These regulations go into effect Oct. 16, 2002, for most entities. Small health plans have an additional year.

The transaction standards deal primarily with information technology issues, but some may affect certain providers, says **Janice Cunningham**, an attorney with The Healthcare Group, a Pilgrim Meeting, PA-based health care consulting firm.

For instance, the standards specify that Diagnostic and Statistical Manual codes no longer are acceptable for mental health illnesses. Providers must use the ICD-9-CM codes. Providers are required to convert to the National Drug Code system for drug coding.

Otherwise, the regulations may be a boon to case managers because they specify a standard format for verification of coverage, authorization for procedures, and referrals. "It should streamline operations, because case managers will be using a standard form instead of a lot of different forms," Cunningham says.

• **Privacy regulations**, which go into effect April 14, 2003, and mandate sweeping changes in the way individually identifiable health information is handled and disclosed. Small health plans have until April 14, 2004, to meet these standards. These will have the greatest effect on how case managers do their jobs. **(For details, see related stories, p. 124.)**

In a nutshell, the privacy regulations mean that the health care industry will have to protect the privacy of patients' medical information, will have to inform patients in writing about how the information will be used, and will have to track and manage the information the way they told the patients they would.

The regulations cover any individually identifiable information, whether it is disclosed during oral conversations, electronic transmission, or written documentation, whether it is by hand, by typewriter, or in a computer.

The final rule establishes civil and criminal penalties for noncompliance. They range from $100 per person per incident for unintentional disclosure, up to a $250,000 fine and 10 years in jail for selling medical information.

The Justice Department's Office of Civil Rights has been given the authority to investigate violations of the final privacy regulations.

A whistle-blower provision allows anyone who says he or she has been hurt by a violation of the privacy regulations to file a complaint. The regulations also allow the Office of Civil Rights to conduct general compliance reviews without a whistle-blower.

• **Security standards**, which protect the confidentiality of health care data that are stored or transmitted. Under the regulations, businesses that transmit or maintain electronic health information must develop a security plan. The final security standards have not been issued.

The preliminary regulations are extremely technical and involved, Cunningham says.

The bulk of the security regulations cover software issues, but they include staff training and physical security of health information, some of which overlap the privacy regulations, she says. These include coding, encrypting information, firewalls to keep hackers out, password protection, and authentication mechanisms to ensure that the right person receives the data. The proposed security standards also contain a chain-of-trust agreement that requires anyone who sends or receives the data to have the same kind of security.

Still in the works are development of unique identifiers for employers, unique identifiers for providers, unique identifiers for health plans, and enforcement procedures. The final rules for these provisions are in development.

The HIPAA law also called for a unique health identifier for individuals, but the U.S. Department of Health and Human Services and Congress have indefinitely postponed any efforts to develop this standard. ■

Cover your bases with HIPAA privacy forms

Privacy notice, consent form, authorization form

When the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations go into effect April 2003, all covered entities will have to produce three sets of forms.

Case managers should familiarize themselves with these forms and make sure their activities are covered, advises **Janice Cunningham**, an attorney with The Health Care Group, a Plymouth Meeting, PA-based health care consulting firm.

These include:

• A notice to patients of the privacy regulations and procedures of that organization. This includes patients' rights to access information, to amend their chart, and what they can do if they feel their privacy has been violated.

• A consent form, authorizing the organization to share protected health information for treatment purposes, payment purposes, and health care operations, such as quality assurance and utilization review.

• An authorization form that enables the organization to use health information for purposes that fall outside the treatment area. Examples include research and fund raising.

Typically, case managers won't have to worry about the privacy notice, because their employer will handle it.

However, you should pay attention to your organization's consent forms, which patients must sign to authorize the release of their personally identifiable health information, says Cunningham.

Case managers should make sure the consent form also includes people to whom your organization's staff may speak about protected health information.

"If you are a case manager, you should have something in writing that authorizes you to speak to any support people, such as spouses, children, or friends if they are the patient's support person," Cunningham says.

Case managers also may have to be involved with activities that require an authorization form.

If you are working in a facility that does drug research and you are required to approach the patient about drug research authorization, you must make sure that the form the patient signs is very specific, Cunningham says. For example, a typical authorization would state that the provider would release a patient's blood test results monthly to XYZ Pharmaceuticals from Jan. 1 to June 30. It should be as specific as possible as to the person or department to whom the information will be released.

If you are working in a rehabilitation facility that wants to use a patient's success story in a fund-raising brochure, you must get a specific authorization for that particular use. A blanket authorization won't work, Cunningham notes.

If you're a case manager in a private practice, you will also have to sign a "business associate" contract with the entities with which you contract.

HIPAA requires a written contract that gives the covered entity assurances that the business associate has systems in place to comply with HIPAA requirements and will abide by them.

The business associate agreement specifies what information may be disclosed and covers any protected health information that you are given or that you create.

If you are contracting with five different insurance companies or providers, expect to have to sign five slightly different business associate agreements, Cunningham says. ■

Learn the components of the HIPAA privacy regs

Here is a synopsis of what the new the Health Insurance Portability and Accountability Act (HIPAA) privacy rules mandate:

1. You must maintain physical security of all health care information.

This includes limiting access to computer terminals and physical access to paper-based documents. Records should be kept under lock and key with limited access.

Nobody should be able to look over your shoulder and see any personally identifiable patient information.

2. Access to individually identifiable health information is restricted to a "need-to-know basis."

All health care entities must develop criteria setting out which employees need to see identifiable health information and identifying the people or class of people who will review the requests for disclosure.

3.. You can disclose only the "minimum information necessary."

For most disclosures, the regulations require you to disclose the minimum information needed for the purpose of the disclosure.

If you work for a provider, you should have full access to the patients' health records, says **David Kibbe**, MD, MBA, chief executive officer of Canopy Systems in Chapel Hill, NC.

However, case managers for insurance companies might have trouble getting the full information in some cases because providers have the obligation to release to the insurance company only the part of the record that is relevant.

"There are areas that are somewhat gray," Kibbe says.

4. Patients have significant new rights of control over their health information.

Patients must sign a consent form allowing providers to disclose their personal health information in the normal processes of treating, billing, and health care management.

The new law gives patients access to their individual health information that is in your organization's files. This means providers must make the records open to a patient any time he or she wants to see them.

The regulations give patients the right to a "disclosure history," which lists entities that receive the information.

5. Patients have to receive a written notification of their rights.

Case managers are not likely to have to provide these written explanations, but you should be aware that your organization has to provide them.

The general notice, which will be given to every patient and posted throughout the office, includes information on patients' right to access information, to amend their chart, and what they can do if they feel their privacy has been violated. It should include a notice of your organization's policies and procedures on use or disclosure of protected health information.

6. All entities covered by the rule must have a privacy officer.

This person is in charge of ensuring that records are handled in accordance with the privacy regulations. If a patient has a complaint about how his records are handled, the privacy officer would handle it.

7. Staff must receive training on your privacy policies and procedures every three years.

The training should cover all aspects of how and why you are protecting health information and should be in conjunction with security training, which will be mandated in the yet-to-be-released security regulations. The staff must be retrained and re-certified every three years.

Your organization will have to provide documentation that training has been given.

8. You must make sure that anyone with whom you share confidential patient information follows the HIPAA privacy regulations.

This regulation could affect case managers in private practice who contract with insurers or providers. However, the onus will be on the covered entity to make sure that the "business partners" comply with HIPAA. ■

HIPAA tied to universal health insurance initiative

More provisions to be released

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) has its roots in former President Bill Clinton's proposed universal health care plan. When that proposal failed, Congress passed HIPAA, also known as the Kennedy-Kassebaum Act and originally a piece of legislation intended to make it easier for people to move their health insurance from one employer to another.

"Instead of just making sure that health insurance was portable and that people couldn't be denied coverage for existing conditions when they changed jobs, Congress took it as an opportunity to look at the health care market as a whole," says **Janice Cunningham**, a health care attorney with The Health Care Group, a Plymouth Meeting, PA-based consulting firm.

A major issue was the paucity of rules on the books about privacy, security, and confidentiality, or who had access to the information, how it could be shared, and what patient consent was needed.

Congress decided that the health insurance portability issue needed to be addressed immediately and passed the law, with a provision giving Congress until Aug. 21, 1999, to pass comprehensive legislation on protecting privacy and ensuring confidentiality of electronically stored medical information.

The act stipulated that if Congress failed to act by the deadline, the secretary of Health and

Human Services (HHS) would create regulations that standardize all electronic data interchange of health information and protect the security of electronic medical records.

Since then, the HHS has released proposed regulations in increments.

The "Transactions and Code Sets" final rule, published by the HHS on Aug. 16, 2000, provides standards for electronic transactions and code sets that health care providers and payers use to identify diagnoses, drugs, and procedures.

When the rule goes into effect, all providers will use — and all health plans must accept — the same electronic transaction standards.

The privacy and security standards were first released in late October 1999 with a 60-day comment period. The final regulations originally were scheduled to be published by Feb. 21, 2000.

Outpouring of comments caused delay

However, HHS received so many comments from the public — more than 52,000 — that the final regulation was postponed over and over.

The original HIPAA privacy rules, signed into law by President Clinton during the final days of his administration, were scheduled to go into effect Feb. 28, 2001, with full implementation due by Feb. 29, 2003. But because of a technicality, the Bush administration halted implementation for further review.

HHS Secretary Tommy Thompson announced in April that he is allowing the HIPAA implementation to move forward without substantial changes, but he added that some of the original rules might be modified as the administration issues guidelines on how the rule should be implemented. ■

HIPAA resources

- **Janice Cunningham**, The Health Care Group, Plymouth Meeting, PA. Telephone: (610) 828-3888, ext. 3327. Web site: www.thehealthcaregroup.com.
- **David Kibbe**, Canopy Systems, Chapel Hill, NC. Web site: http://www.canopycentral.com.
- **U.S. Department of Health and Human Services**. Web site: http://aspe.hhs.gov/admsimp/www.hhs.gov.
- **American Hospital Association**. Web site: http://www.aha.org./hipaa/hipaa-home.asp.
- **American Health Information Management Association**. Web site: http://www.ahima.org.

Slash hospitalization, lengths of stay for elderly

Geriatric nurses manage high-risk patients

By case managing high-risk elderly patients, Carle Clinic Association, PC, in Mahomet, IL, has shortened lengths of stay and improved care for targeted patients. The population served by the Partners in Care program includes 2,000 capitated Medicare managed care beneficiaries who are at high risk for mortality, functional decline, and increased use of health care resources.

Since its inception in 1998, Partners in Care has dramatically reduced the utilization of health care resources for patients in the program. For example, patients in Partners in Care were hospitalized for a total of 1,721 bed days per thousand per year, compared to 4,162 bed days per thousand per year among a similar population not in the program. Program participants were hospitalized 433 times per thousand per year, compared to 858 times per thousand per year for patients not in the program. And Partners in Care patients visited their physicians 13.2 times a year vs. 11.8 visits for those not in the program.

Carle Clinic Association is a multispecialty physician-owned practice with 290 physicians in primary care and medical surgical specialties. The practice is part of a health care system that includes a hospital, HMO, and other service companies, such as home health, pharmacies, and durable medical equipment suppliers.

The Partners in Care program received the Models of Excellence in High-Risk Patient Management award from the American Medical Group Association (AMGA), in Alexandria, VA, and New York City-based Pfizer Inc.

Nurse case managers, called Nurse Partners, are the linchpin of the Partners in Care program, says **Tuni Miller**, RN, MS, Community Nursing Organization program manager. **(See outline of job duties, p. 127.)** The primary care physicians provide geriatric care and serve as team leaders. **(To learn about the evolution of this dynamic, see story, p. 128.)**

The Nurse Partners actively monitor the patients. The nurses visit the patients in multiple venues, such as their homes, the hospital, or the nursing home, in addition to the clinic.

They give the information they gather during site visits back to the primary care physician.

"This really helps with the ongoing support of the patient population. It helps the patients understand what is happening, what kind of treatment and recommendations their physicians have; and it helps the patients implement the recommended treatments," says **Cheryl Schraeder**, RN, PhD, FAAN, who heads the health system research center.

When patients are healthier, fairly self-sufficient, and have an active lifestyle, contacts are minimal. Patients who are frailer receive a comprehensive assessment to determine all their risk factors, as well as periodic assessments and visits. For example, the Nurse Partners keep a close watch on blood sugar levels, cardiac signs and symptoms, and weight for patients with congestive heart failure. **(To learn how the program screens potential participants and determines their risk status, see story, p. 128.)**

"Early detection can ward off serious acute episodes that land the patients in the hospital," Miller says.

The Nurse Partners work with patients, families, and physicians to help the patients maintain a healthy status so they can stay at home. They teach patients self-management and better ways to take care of themselves, and help them manage chronic conditions.

The Nurse Partners telephone the patients at regular intervals, again depending on the health status of the individual. For example, the healthier patients may receive a call only once every six months. Patients who have just had an acute episode may be called once a week.

"It ebbs and flows," Miller says. "The Nurse Partners use their clinical judgment to decide how frequently the patients should be contacted. We also encourage them to call us if they have any questions or concerns."

What makes the Nurse Partner program unique is that it covers the acute care, home, and community settings.

When a patient in the program is admitted to the hospital, the Nurse Partners work with the hospital case coordinator (formerly known as discharge planners) to provide information and help plan for the patient's discharge.

The Nurse Partners coordinate any services that are needed after discharge and follow up after the patient returns home. The Nurse Partners often work collaboratively with people in the hospital, the home health agency, community organizations like the Office on Aging, and the physician's office.

"One issue with an elder who has multiple needs is hooking them to appropriate services such as Meals on Wheels," Schraeder says. "Partners in Care really helps to provide continuity, monitoring, and support for a person with complex care needs."

Each nurse manages the patients of specific primary care physicians. There are about eight nurse partners, each of whom supports patients from five to six primary care physicians, spread out in clinics throughout the Carle Clinic Association treatment area.

The Nurse Partners are coordinated by a nurse manager and program developer and are assisted by care assistants, most of whom have worked in community agencies. Care assistants answer the telephone, take care of some administrative tasks, arrange for services, such as a homemaker service, and do some telephone monitoring, checking in with the patients and alerting the Nurse Partner if the patient needs to make an appointment.

(Editor's note: To order a copy of a Compendium of the AMGA-Pfizer Models of Excellence Awards, *which contains detailed descriptions of 16 high-risk patient disease management programs, visit the AMGA web site at http://www/amga.org. The organization is now soliciting nominations for the Models of Excellence awards for 2002. An application may be downloaded from the web site.)* ■

Nurse Partners perform a variety of jobs

The Nurse Partner concept combines the duties of an office nurse with a community-based home health provider. These jobs include:

- performing the initial assessment and developing a care plan;
- facilitating communication between the physician and patient;
- regularly calling the patient to ascertain his or her health status;
- acting as a patient advocate to help the elderly and their families obtain community care;
- seeing the patient in the hospital, the nursing home, or the home;
- working with discharge planners, home care nurses, and payers. ■

CMs partner with docs to help high-risk elderly

Concept evolved over 12-year period

When the Carle Clinic Association launched its Partners in Care program for the elderly, the Mahomet, IL-based multi-specialty practice already had 12 years of case management experience with seniors under its belt.

The current program evolved from a case management model designed to address the needs of the rapidly growing geriatric population the clinic leaders knew they would be serving in the future.

"We went through a lot of changes in the model. We started with volunteers, then nurse/social workers, and finally found that the best solution was a community-based specially trained nurse," says **Cheryl Schraeder**, RN, PhD, FAAN, who heads the health system research center.

Carle Clinic Association started a case management program for the elderly in 1986, with initial funding from the Kellogg Foundation, Schraeder says.

"When we started the concept, it was ahead of its time. There was nothing like it in group practice in the country," Schraeder says. "Most of the case management at that time was in the social service field with under-served populations, primarily in psychology and public health."

At the time, nurses were not an integral part of case management programs. This was a concern to the Carle Clinic leadership because they had found that older adult patients, particularly those from the rural areas served by the clinic, often were reluctant to describe accurately how well they were functioning.

The clinic doctors and nurses had found that the patients felt freer to discuss their living situations and health problems with the nurses, rather than the doctors. The solution seemed to be an integrated program in which the nurse works with the primary care physician, the patient, and the patient's family to develop and coordinate a health care plan.

The practice tried having all of the nurses working in a centralized setting, then moved on to having them decentralized but in their own space. They found that it was most effective for the nurses to be in the community clinic setting where they can be aligned closely with the primary care physicians to enhance the team treatment concept.

That led to the current system in which the nurses, called Nurse Partners, are located in clinics throughout the clinic's treatment area and are responsible for managing the care of patients for specific primary care physicians.

"We tried all kinds of communication with physicians, including e-mails and written summaries, but we found that if the physicians and nurses are in the same facility, they can communicate in the hallway or before the start of the day and do quick case reviews instead of scheduling long-term meetings," notes Schraeder.

The clinic is one of 15 sites chosen to participate in a Medicare Coordinated Care Demonstration Project. It is taking the same concepts and applying them to chronic conditions such as diabetes, chronic obstructive pulmonary disease, coronary artery disease, stroke, and congestive heart failure. ■

Program focuses on elderly with highest risks

Patients are carefully screened

Carle Clinic Association in Mahomet, IL, carefully screens the patients who are chosen to participate in its Partners in Care case management program.

The typical patient has two or more chronic conditions, such as congestive heart failure, diabetes, cancer, stroke, or coronary artery disease, and takes at least five medications daily. Patients have limitations in activities of daily living (such as walking or feeding themselves) and instrumental activities of daily living (cooking, driving, and shopping), as well as a history of previous hospitalizations.

Over time, the practice has automated its identification system to identify patients at risk who should be referred to the program.

"We are continually refining and automating our clinical records and triggering systems," says **Cheryl Schraeder**, RN, PhD, FAAN, who heads the health system research center.

Medicare patients who have seen a family practice or an adult medicine physician more than four times a year are referred automatically to the program. Patients also are referred to the program directly by physicians.

Once referred to the program, a patient receives a 50-item questionnaire that gathers information such as demographics, medications, current health conditions, and prior health care service utilization.

The information from the questionnaire is entered in a computer database that classifies patients into risk categories based on their response to certain questions. For example, a patient who has positive responses to three of 13 "trigger" questions initially is given a status of "At Risk."

A nurse, known as a Nurse Partner, conducts a second, more detailed screening either during an office visit or over the telephone. Using this information, the nurse and physician determine the patient's final risk status.

Participating patients are given a medical assessment by the physician to determine current and potential medical and psychosocial needs. Then, the patient, physician, and nurse develop a coordinated health care plan that includes medical services, community services, and assistance from family, friends, and neighbors. ■

HMOs cooperate to reduce infant mortality rate

Project tracks pregnant Medicaid patients

Concerned by low birthweights and high infant mortality rates in the Philadelphia area, four HMOs have collaborated on a project to improve birth outcomes in the Medicaid population.

The Healthier Babies project identifies and tracks the behaviors and health status of pregnant Medicaid women in a five-county region of southeastern Pennsylvania.

The data collected in the Healthier Babies database will give insurance company case managers the information they need to determine which pregnant women need interventions to improve their health and that of the babies, says **Richard J. Baron**, MD, president and CEO of Healthier Babies Inc. in Philadelphia.

The average physician's office does not have the ability, knowledge, or resources to solve the problems that cause low-birthweight babies, Baron points out.

"The managed care providers have the ability to follow women longitudinally across sites," he says. "No individual physician can do that."

Since May 1998, the Healthier Babies project has collected data on close to 300,000 encounters and some 40,000 patients.

"We are an active regional coalition of Medicaid managed care organizations," says Baron. "The approach we are taking is to standardize clinical data collection and to work together to standardize the data, to understand what it means to the population, and to offer interventions to women when we think we can make a difference."

For example, through data analysis, the coalition has been able to identify the relative risk of cocaine use, a history of domestic abuse, or illness as a predictor of poor birth outcomes in the Medicaid population.

"It's not that what we've learned has been surprising, but we know that we are getting good information," says Baron.

The project gives HMO case managers a wealth of data they can use to design interventions for their Medicaid population. For example, in about seven seconds, a case manager can get a list of all of the HMO's pregnant women who say they use cocaine. "The technology is impressive," notes Baron. "It finds the needle in the haystack."

The data give the plan the ability to use the information on the population they cover to decide which interventions might work.

"The plans have built their own risk assessment scoring system based on the data to produce reports of high-risk pregnant women," explains Baron. "It can drive their prenatal case management system."

For example, one plan may design an intervention for pregnant women who smoke. Others may use the data to design a diabetes management program, to institute nutritional programs, to find shelter and food for homeless pregnant women, and to schedule cesarean sections for HIV-positive patients or drug users.

Before the project was implemented, the four participating HMOs had four different methods for collecting clinical data on their Medicaid patients. Many times the data collection and reporting fell between the cracks because the various types of paperwork and ways of reporting made it impossible for physicians to comply, Baron adds.

"There was no way that the doctors could comply with four different procedures for these patients," Baron says. Now, there is a standard

form for collecting data for all HMOs, which operate across five counties.

One significant achievement has been that health plans are able to significantly increase their HEDIS scores when they add the data from the Healthier Babies project.

"What is interesting is that people assume that the best data are going to be claims information, because if there is money on the table, someone will figure out a way to bill for it," Baron says

One HMO was paying a $225 incentive to providers for reporting the first visit of a pregnant woman on Medicaid within 48 hours. Their HEDIS scores still improved when they added Healthier Babies information.

All providers who see pregnant women covered by the four Medicaid HMO plans use a universal prenatal encounter form to identify and track the health behaviors of their patients.

The reporting system is voluntary. The HMOs involved made it an administrative requirement but did not set up sanctions for providers who don't comply.

The fact that there is good compliance points out that a common reporting system is a superior way to collect data and analyze claims, Baron says. "We've validated the hypothesis that you can change the culture if you are all on the same page," he adds. ■

Deal proactively with patients' psych problems

Early treatment saves money down the road

Have you ever had an injured patient who just wouldn't get better no matter how many treatments or modalities he received?

You might think the patient is malingering — making up symptoms to stay out of work or to get more money from a settlement.

But the problem likely goes deeper than that, says **Laurence Miller**, PhD, director of psychological services at Heartland Pain and Rehabilitation in Lantana, FL. If you suspect that psychological issues may be interfering with a patient's recovery, refer the patient for a psychological evaluation, he suggests.

In fact, Miller, a clinical psychologist, recommends that case managers routinely refer all patients with a potential disability for psychological screening.

Not only will a routine psychological screening help you identify patients who might need more than physical treatment for their condition, it will help ease some patients' resistance to receiving psychological services.

"You can justify that it is part of the regime. That way, it's not stigmatizing," he says. By the time you know the patient isn't responding for treatment, the patient is already stigmatized, and it's the worst time to send him for evaluation, he adds.

"It will save money to aggressively treat the syndromes up front," says Miller. "The longer you wait, the more money you'll spend."

If your program won't allow routine psychological evaluations, make sure the patient gets a referral if you suspect any kind of psychological problem, he suggests.

"It may be difficult to make the referral. You've got to justify it from the expenditure point of view, and most patients don't want to be sent to a psychiatrist," he notes. "No matter how you explain it, all they hear is that you think they're making up their symptoms."

Psychological treatment will not cure every patient, but you can make a dent if you do it early, Miller says. In other countries, where there are state-sponsored compensation systems that treat patients — and no lawyers get involved with their care — the return-to-work rates are much better than in the United States, he says.

The best results are when treatment begins within six months post-injury, he adds. "Anxiety is situationally based. As time goes on, the disability becomes entrenched."

Make sure that at some point during treatment, someone sits down and explains as clearly as possible what is wrong with the patient and what can be done.

"Patients need a reality check," suggests Miller. "In many cases, they are never given a clear message as to what is wrong with them."

Some patients do indeed malinger, but more fail to get better for reasons that don't show physical symptoms, he says.

"Malingering is not a diagnosis. When someone says a patient is malingering, they are calling them a liar and a thief and a perjurer. That is accusing them of consciously and knowingly making up symptoms to gain something, like money, or to avoid something, like a criminal conviction," Miller says.

Fabricating symptoms or making up a syndrome out of nothing is a pretty unusual occurrence, he says. For a patient to exaggerate his or her symptoms is more common. Physicians often don't see the patient's psychological problems, even when the symptoms are not consistent with the physiological injuries, Miller says.

"Most orthopedists, neurologists, and even some psychologists and psychiatrists don't have the knowledge of the full range of things that can affect rehab," says Miller.

The biggest dilemma that case managers and other clinicians face is that they often must decide between two possibilities: Either it's a legitimate injury or disability, or the patient is making it up. "Those choices don't give you much clinical wiggle room," he notes.

Legitimate disorders abound

There are a lot of legitimate disorders that may be confused with malingering, particularly in the rehabilitation setting, Miller says. For example, there may be symptoms that aren't fully explainable or attributable to a patient's medical condition or injury. The patient may unconsciously be blowing his symptoms out of proportion because of a somatoform disorder.

"The underlying psychological reason is usually to fulfill another unfilled need," Miller says.

One common example is that the person feels he or she has not been treated fairly, and the employer or insurance company becomes the focus of those feelings. "When people talk about how unfairly they are treated, it's easy to dismiss it as neurosis," says Miller. "But in many cases, the system does abuse and unfairly fail to treat patients."

Another example typically occurs among young blue-collar workers. Having been told all his life about the value of hard work, an employee subconsciously wishes he could slack off, so he exaggerates his disability because it allows him to work less.

You may see a patient with an injury that seems minor in itself, but there was a prior head injury or other injury that could explain it. This is called misattribution. "It may be a cumulative effect so that the present injury, though minor in and of itself, is more severe than expected," says Miller.

Patients who suffer from hyponchondriasis are convinced that they have a serious illness or injury in spite of the medical evidence against it. Many of these patients are afraid to go back to work for fear that their illness or injury will return. ■

HCFA's got a new name

Change is first step in reform

The federal agency that runs the Medicare and Medicaid programs is now the Centers for Medicare and Medicaid Services (CMS).

The name change was announced June 14 by U.S. Secretary of Health and Human Services Tommy G. Thompson, who noted that the new name is part of a series of initiatives aimed at increased responsiveness to beneficiaries and providers and improved quality of care.

CMS will be split into three divisions:

• The Center for Medicare Management will focus on managing the traditional fee-for-service

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Editorial Questions

Questions or comments? Call **Russ Underwood** at (404) 262-5521.

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Medicare program, including development of payment policy and management of the Medicare fee-for-service contractors.

• The Center for Beneficiary Choices will provide beneficiaries with information on Medicare, Medicare Select, Medicare+Choice, and Medigap options. It will manage the Medicare+Choice plans and consumer research and demonstrations, and handle grievance and appeals functions.

• The Center for Medicaid and State Operations will oversee programs administered by the states, including Medicaid, the State Children's Health Insurance Program (SCHIP), insurance regulation functions, survey and certification, and the Clinical Laboratory Improvement Act (CLIA). ■

5. Which of the following sets of regulations is not included in the Health Insurance Portability and Accountability Act (HIPAA) of 1996?
   A. transaction standards.
   B. security standards
   C. privacy standards
   D. patient safety standards

6. Mahomet, IL-based Carle Clinic Association's Partners in Care program targets what patient population?
   A. pediatric patients
   B. OB/GYN patients
   C. high-risk geriatric patients
   D. cardiac patients

7. In the Partners in Care program at Mahomet, IL-based Carle Clinic Association, a patient is given a status of "At Risk" if he or she gives positive responses to how many "trigger" questions?
   A. one
   B. three
   C. six
   D. seven

8. Since May 1998, the Healthier Babies project has collected data on approximately how many patients?
   A. 10,000
   B. 20,000
   C. 30,000
   D. 40,000

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 case managers encounter in their daily case management activities. ■

Reports From the Field™

Hypertension

Hypertensive women don't receive the care they need

The quality of care for women with high blood pressure falls considerably short of medical standards, according to a RAND report published in the *Archives of Internal Medicine*.[1]

The study of 613 women enrolled in a West Coast managed care plan showed that the average woman receives less than two-thirds of the essential, scientifically validated care she needs.

Blood pressure screening occurred at rates exceeding 80%, but of the 234 women diagnosed as hypertensive (with an average blood pressure greater than 140/90 mm HG), most did not receive an adequate initial history, physician examination, or laboratory tests. Only 37% of those with blood pressure persistently exceeding 160/90 were advised to make changes in their therapy or lifestyles.

"Our results also showed a clear relationship between better care processes and better blood pressure control," says lead researcher **Stephen M. Asch**, MD. "While our study covered only women, there is no reason to suspect that care for men would show a significantly different pattern."

Reference

1. Asch S, Kerr E, Lapuerta P, Law A, et al. A new approach for measuring quality of care for women with hypertension. *Arch Intern Med* 2001. 161:1329-1335. ▼

Urology

Prostate cancer patients getting better outcomes

Prostate cancer patients who have their prostate removed have a better prognosis today than patients who underwent the procedure 10 years ago, according to a study presented at the American Urological Association's June meeting in Anaheim, CA.

When researchers at Memorial Sloan-Kettering Cancer Center in New York City retrospectively examined data from 6,556 patients who had a radical prostatectomy between 1985 and 2000, they found that the year the patients underwent the surgery was a good predictor of their prognosis.

"Improved patient outcome may be due to earlier detection of less advanced cancers, improved surgical technique, or the ability to more accurately measure the prostate's clinical characteristics before surgery," says senior author **Michael Kattan**, PhD. According to the American Cancer Society, earlier diagnosis has helped improve the survival rate for all stages of prostate cancer to 93% over the last 20 years. ▼

Early radiation therapy may reduce cancer recurrence

Early radiation therapy following a prostatectomy may reduce the likelihood of cancer recurrence by two-thirds, a study at Lahey Clinic

in Burlington, MA, has concluded. The study was released at the American Urological Association's June meeting in Anaheim, CA.

"The use of radiation within six months of a prostatectomy in which the disease has spread beyond the prostate capsule can make an enormous difference in the recurrences of the disease," says principal investigator **John A. Libertino**, MD, chair of Lahey Clinic's department of urology.

The researchers followed 296 patients (average age 61) who underwent a radical prostatectomy for cancer that had spread. Sixty-six patients received early adjuvant radiation therapy. The rest received hormonal therapy or delayed radiation therapy when the disease recurred.

The 66 patients who received early adjuvant radiation therapy had a 12% recurrence rate, compared to a 38% recurrence rate for patients who received hormonal therapy or delayed radiation therapy at the time of recurrence. ▼

Chemotherapy may help in recurrent prostate cancer

A combination of chemotherapy and hormone therapy may be effective in controlling recurrent prostate cancer, reported researchers from the University of Maryland Greenebaum Cancer Center in Baltimore at the American Urological Association's June meeting in Anaheim, CA.

In the study, men with prostate cancer that had recurred after surgery or radiation treatment were given the chemotherapy agent docetaxel, followed by hormone therapy.

"Traditionally, chemotherapy is not used for this group of patients," says **Arif Hussain**, MD, a prostate cancer specialist at Greenebaum Cancer Center. "It is often reserved for men who have advanced, metastatic prostate cancer, following hormonal therapy. In this study, we are reversing the order of treatment for men with early recurrent prostate cancer by giving them chemotherapy first, followed by hormone therapy."

So far, the researchers have evaluated 26 patients, finding a 57% decline in levels of prostate-specific antigen in patients who received the treatment regime.

"Unfortunately, most advanced prostate cancers develop resistance to traditional therapies over time. By using chemotherapy first for inpatients with early, recurrent disease, we may be able to more effectively kill prostate cancer cells before they develop resistance," Hussain says. ▼

Multiple sclerosis

One-stop MS information

A new web site features extensive information about multiple sclerosis and encourages early diagnosis and treatment. Launched in June by Accel Healthcare Communications, Multiplesclerosis.com is geared to people with MS, their families, friends, and health care providers.

The site includes breaking news; articles from scientific and medical journals; signs, symptoms, and diagnostic tests; and treatment options, including alternative and experimental therapies. The web site also has tips on living with the disease, monitoring disease progression, managing and preventing treatment side effects, and complying with therapy. The section for professionals covers practice guidelines, medical conference highlights, resources, an advanced literature search engine, links to other web sites, and recommended reading. ▼

Neurology

Alzheimer's drug may help vascular dementia

Patients with dementia caused by cerebrovascular disease, such as stroke, may benefit from a drug that has been approved for patients with mild-to-moderate Alzheimer's disease. A six-month study presented at the World Congress of Neurology shows that Reminyl (galantamine hydrobromide) maintains memory, orientation, and language skills for a year in patients with both dementia and cerebrovascular disease.

"If the findings of this study are replicated through further research, physicians can be more confident about treating dementia in individuals in whom vascular damage has occurred," says **Roger Bullock**, MD, of the Kinghill Research Centre in Swindon, United Kingdom. ■