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Case Management ADVISOR™

Covering Case Management Across The Entire Care Continuum

INSIDE

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Take an active role in your organization's HIPAA effort

Case managers have expertise to share

Case managers should be involved in their organization's Health Insurance Portability and Accountability (HIPAA) compliance initiatives, but in many cases, they're left out of the planning, **Linda Reeder**, RN, MBA, FACHE, RNCm, has found.

"What I am seeing that concerns me is that certain key disciplines, including case management, are not being involved in their organization's HIPAA steering committee or being actively involved in one of the work groups," says Reeder, president of Envision Consulting, a Seattle e-health and clinical information technology consulting firm.

Less than a year remains for organizations to comply with the first of the regulations that go into effect under HIPAA, and efforts at meeting the deadline should be well under way at all covered entities, which include providers, payers, and health care information clearinghouses.

Case managers, quality managers, and educators often are not involved when their organization's processes are being evaluated to comply with HIPAA, but because of the sheer number of people with whom they interface, case managers have a lot of valuable information to offer, Reeder says.

Case managers should make an effort within their organizations to be involved in HIPAA planning, particularly efforts to comply with the privacy standards and in work groups that analyze the business procedures related to key transactions, Reeder says.

"Since case managers deal with and coordinate services for external parties, they need to be at the table and dealing with the operative issues. Case managers have a real understanding of work flow and could be an important factor in the organization's compliance plan," Reeder says.

HIPAA offers opportunities for case managers to expand their roles in their organizations. For instance, case managers are in a good position to

assume the role of their organization's privacy officer, Reeder suggests.

"Because a good part of HIPAA is education, and case managers are skilled in that area, they are in a unique position and have a real opportunity to play a central role," Reeder says.

Case managers have the educational background; they know the parties involved; and they have a lot of expertise on how the system works. Being a privacy officer in your organization could be a career step.

"Case managers should position themselves and their organizations as being a leader in privacy and e-health. They can be emphasizing to the parties they interface with what their organization is doing to protect client privacy," Reeder says.

Another reason case managers should be involved with their organization's HIPAA task force is to make sure their needs and daily functions are met when the security regulations are enacted. Under the security regulations, access is limited to "need to know," and, based on your job or your role in the company, you may not be able to access certain information. ("Need to know" means whether a certain piece of information is needed for the purpose for which the release is generated.)

"Case managers should work closely with the security officer to make sure they don't get more than they need but that they do have access to all the information they need," says **Beth Hjort**, HIA, AHIM, practice manager for health information management for the American Health Information Management Association in Chicago.

"The spirit of HIPAA is that the patient remain in control of his or her protected or individually identifiable health information," Hjort says.

At present, HIPAA regulations fall into three categories: privacy, security, and transaction and code set standardization.

• **The privacy regulations** are scheduled to go into effect April 2003. They mandate changes in the way individually identifiable health information is handled and disclosed. The U.S. Department of Health and Human Services issued proposed changes to the HIPAA privacy regulations on March 27, 2002.

The proposed changes in the HIPAA privacy regulations have strengthened the marketing requirements. Now, patients must sign a specific authorization to have their health care information used in external marketing programs.

The changes also give entities an additional year to revise contracts with business associates. The result will be that, instead of having to renew all contracts and make them compliant with HIPAA before April 2003, organizations can add HIPAA language over time as the contracts expire.

• **The security standards** protect the confidentiality of health care data that are stored or transmitted and require covered entities to develop a security plan. The final standards are expected this summer, but experts don't expect them to be significantly different from the proposed regulations.

At present, because the deadline for complying with the HIPAA privacy regulations is earlier than the transaction standards deadline, many organizations are concentrating on their privacy compliance efforts.

• **The transaction standards** set out standardized ways that patient health, administrative, and financial data can be transmitted. The effective date of these regulations has been postponed until Oct. 16, 2003, if covered entities apply for the extension and show a good-faith effort at compliance to date. ■

Some HIPAA issues may be unique to case managers

Think through your solutions in advance

If you work for a large organization, the Health Insurance Portability and Accountability Act (HIPAA) practices that are defined for your

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organization would apply to you as you practice in that environment.

However, case managers will have some unique challenges with respect to HIPAA compliance.

For example, there may be some other areas you have to grapple with, particularly when it comes to privacy issues, such as the requirement that you give referral sources only the minimum necessary information, points out **Linda Reeder**, RN, MBA, RNCm, president of Envision Consulting, a Seattle e-health and clinical information technology consulting firm.

The variety of organizations and agencies that the case manager deals with will require careful consideration of what each needs to know. "They may have gotten used to giving these agencies all the information about a client, but under HIPAA they have to be careful," Reeder says.

In addition, some of the organizations that case managers refer clients to are not covered entities as defined by HIPAA. For instance, job-retraining agencies generally are not covered by HIPAA, as they do not provide health care services. However, they are business associates, and the case manager needs to ensure that contracts with these organizations contain appropriate clauses requiring the associates to protect any health information.

Social service vs. medical model

Furthermore, these business associates may very well be unaware of HIPAA, which requires case managers to educate them on the requirements.

"A lot of case managers straddle the line between a social service model of care management and a purely medical model of care management. However, the HIPAA transaction and code set regulations were developed around the medical model," Reeder says.

Typical case managers are as involved in social support activities as they are in coordinating direct health care services. They deal with independent living skills, transportation, education and literacy issues, community programs, and other activities that help patients get the social support they need to deal with their medical issues.

Trying to fit a social services model of care into the HIPAA model may be difficult.

For instance, a developmentally disabled person needs medical services but also needs job training, independent living skills, personal care, and transportation.

Therefore, the eligibility, enrollment, billing, and payment processes do not follow the typical "medical model" but still need to be HIPAA-compliant if the case manager's organization does business electronically.

Transitions and code sets

The security regulations may produce the biggest changes in practice for case managers, particularly if they are out in the field, where mobile computing devices and remote access are increasingly commonplace. For instance, you'll have to deal with the physical security of the records, whether they are in your office or in the field, including the records that might be included in handheld devices or laptops.

Case managers should make sure they review their organization's policies and make sure that the people creating the policies understand the case manager's role in the field.

It's a big mistake to ignore the transaction and code set rules, thinking it's simply a technical issue, Reeder says.

"The transaction and code set regulations represent the real value for case managers. Having standardized code sets and data gathering will facilitate e-case management and e-health. It could to be a big efficiency boom for case managers," Reeder says.

The way you authorize treatment, enroll participants in disease management and other programs, or set up referrals to providers is likely to change dramatically.

When the transactions and code sets for health care are standardized, you'll be able to go on-line to check eligibility, get authorization for treatment, submit claims, and check on the status of payments. In addition to other online activities such as scheduling appointments, checking diagnostic results, performing utilization review, and other activities, this can significantly improve the workflow for case managers.

HIPAA has the potential for saving money by streamlining the business processes of health care. Reeder cites studies that estimate that checking eligibility or issuing a referral could drop from a cost of approximately $20 or more to less than $1 if it's done electronically, using standardized transactions and code sets.

HIPAA regulations will mean you'll have to take additional steps to ensure that your client's protected health information is secure, particularly when you use today's technology, points out **Beth Hjort**, HIA, AHIM, practice manager

for health information management for the American Health Information Management Association in Chicago.

For instance, you will have to be extremely careful when faxing identifiable health care information that the information goes to the proper person. It's easy to misdial a telephone number or hit the wrong button on a speed dial, sending the information to the wrong recipient.

Cell phones pose another security risk, because conversations can be intercepted.

Here are some other areas case managers should look at when they think of HIPAA compliance, Hjort suggests:

- Gather together the main functions you do that involve release of information. Look at the mechanisms you use to access and share the information and make sure they are secure.
- Work closely with the security staff to make sure that an infrastructure is in place to protect each mechanism.
- Get in the habit of using a call-back procedure to know who is on the other end of the telephone line. "It's a good fall-back to help validate that you are getting through to the right organization," she says.
- Ask your security people to ensure that your e-mail is secure.
- Make sure that the privacy rules cover all employees, no matter where they work. For instance, if your case managers work at home or access patient records from home, make sure their computers and telephones are secure.
- Make sure a policy on personal digital assistants and laptop computers is in place to secure the data in the best way possible. Laptops and personal digital assistants are of concern because it's difficult to secure them physically.
- Make sure your staff are available when your organization's HIPAA information training is given. Keep up with new procedures, updates, and reminders.
- Be a team player and part of the core of people key to making sure privacy is honored.
- Examine the physical security measures within your department. For instance, do you secure hard-copy records overnight, where they can't be seen by the cleaning staff or other unauthorized people? Is your fax machine located in a secure place, where the faxes can't be read by everyone? Do you and your staff routinely log out when you leave your computer workstation, rather than leaving protected information on the screen? ■

Cost-benefit analysis can help you choose treatment

Formula shows the benefits of case management

A cost-benefit analysis can help case managers face the daily challenge of getting their patients the most cost-effective care with the best outcomes.

"With the way health care is going, the bottom line is finance. You have to financially justify what you are doing and why you are doing it," says **Ann H. White**, RN, PhD, MBA, CNA, associate professor of nursing at the University of Southern Indiana in Evansville.

By comparing the cost of treatment with the benefits of various plans of care, you can help the treatment team come up with the best treatment plan for that particular patient.

It's a technique use to demonstrate what a case manager can do and to retrospectively demonstrate the cost of savings in the plan you chose, White says. **(To learn how to do a cost-benefit analysis, see chart on p. 65.)**

Here's a simple example of how to use a cost-benefit analysis.

You have an elderly patient with a hip fracture, diabetes, and a family member who lives in the same city. Your treatment options following hospitalization are:

Plan A: Transfer the patient to a skilled facility for four weeks and then send him home with four weeks of home health.

Plan B: Keep the patient in the skilled facility until he is able to function independently.

Plan C: Send the patient straight home from the hospital with more intensive home health and physical therapy.

"If you can demonstrate that the outcome will be the same, then you have a persuasive argument to implement that plan that is more efficient and most effective," White says.

But there are "ifs" involved, White points out.

For instance, if you can do only what the physician tells you to do, and he or she won't listen to an alternative plan, you are wasting your time.

"If a doctor says a patient's going to be in the skilled facility for four weeks and then go home, there's not a lot that cost-benefit analysis can do," she adds.

You have your best chance to influence the plan of care when you have a good relationship

with the treatment team.

"If you have a relationship with the physician and the treatment team, you can show them the options and what is the most appropriate way to go for this particular individual," he says.

It's a simple technique, but it's not an easy solution to all your problems.

Intangibles are what make cost-benefit analysis so hard, White points out.

"The formula itself is easy, but getting the numbers is extremely difficult, and that's the huge challenge," she adds.

Another challenge, she points out, is putting the numbers together so they look realistic.

"If the chief financial officer doesn't believe your numbers, it doesn't make a big difference whether you saved $2,000 or $20,000. It's always a challenge to be realistic and demonstrate that you are really doing something," White says.

One problem that arises is that when case managers are called in to do a cost-benefit analysis, the cost of case management is seen as going on the negative side of the financial page.

"But if by doing a cost-benefit analysis, the insurance company or whomever can save $20,000, they're going to be interested in looking at the option, despite the fees," White adds.

You don't want to be in a position where your fees cost your client money but there's not a real change in the bottom line, she says.

"A lot of people equate case management with saving money. These are the people who say whether you can do it because of the bottom line. The intent of a cost-benefit analysis is to look at the outcome and the client as well as the bottom line," she says.

"You don't want people to think they have to do Plan C because it saves money. That's not the intent of a cost-benefit analysis," she adds.

The cost benefit analysis is just one piece of information that should be brought to the table when the treatment team decides how a particular client's case should be handled.

Choose your cases carefully. For instance, you might not do a cost-benefit analysis on a patient with a fractured hip who has family support. But you might choose to do one on a patient with a fractured hip who has diabetes and no support at home.

"Collecting data and weighing it can take a phenomenal amount of time. You need to look at the advantages and disadvantages of doing it on every single case. It has to be a call by the institution in most cases," White says.

Five steps to performing a cost-benefit analysis

1. Start with a summary of the individual case.
2. Add documentation about anticipated outcomes and what the ultimate goal is.
3. Identify the treatment options. Look at how they fit into the patient's particular situation and how they will help achieve the goals.
4. Come up with the cost of each option. Be sure that you obtain the costs for each plan of care, not the charges, so you won't be comparing apples to oranges.
5. Compare the various options and their cost and outcome.

For instance, a patient between 65 and 75 years old with a fractured hip and no co-morbidities probably would be a lot like other, similar patients. It would not be good use of your time to do an analysis on every single one. What you should do instead is trend the data over time and perform a cost-benefit analysis on a few cases every six months.

"Once we know what is typical, we need to do an analysis only on those who fall out of the norm," White says.

On the other hand, care of patients with a high-risk pregnancy or babies in the neonatal intensive care unit is so expensive that every case is unique and you might want to do a cost-benefit analysis for each case. ■

Increase your value by projecting cost of care

Put financial knowledge to work for you

As a case manager, you are in a unique position to help your organization accurately project its health care costs and stay profitable in the future.

That is because you know the patients and the treatment they require.

But many case managers don't know how to take the knowledge they have and express their value to their organizations, says **Joann C. Milne**, RN, BSN, CRRN, PHN, assistant vice president of medical management programs with IOA Re, with headquarters in Plymouth Meeting, PA.

"Clinical knowledge, along with financial knowledge, is a very powerful tool for case managers working for an HMO, an employer group, or a direct insurer to use to validate their worth. Knowing this, case managers should be able to speak up and better communicate their worth," she adds.

Unfortunately, many case managers in all areas of the industry do not understand how to look at a case and determine what it will cost financially over a period of time, Milne says.

"This is not part of the curriculum we are taught in school or part of our employers' standard expectations. Why? Because the concept of how our clinical knowledge, coupled with financial awareness, can impact an organization's profitability, is just evolving.

However, she adds, it's essential that case managers take it upon themselves to learn to determine and project their worth in a multitude of ways to the people who hold the keys to their professional and financial futures.

"Case management faces a lot of challenges. Either we produce savings and effectively communicate our value, or we tend to perish. We've got to be able to show a return on investment," she says.

It's not enough to do a claimant/member-specific return on investment report. These are open to being torn apart by the financial people, who don't understand the role of case managers and who could say that the physician might have discharged the patient two days early anyway, without the intervention of the case manager.

"Case managers are scrutinized when we report hard and soft savings. People ask if the savings were truly due to our intervention. As a profession, we need to learn new ways to make our value stronger within an organization," she says.

Understanding cost

One of the hurdles case managers face is that they often view themselves as nurses and not "financial people." In addition, in some people's minds, there is a conflict between knowing the finances of managing a case and managing a case with patient advocacy in mind, she adds.

"Some people feel that if they are looking at cost, they can't be looking at patient advocacy, but this is not true," she says.

As a case manager, you must understand cost. A key part of the practice of case management is to promote high-quality, cost-effective care.

"We can't promote cost-effective care without a strong knowledge of what care costs. If you take the cost-of-care knowledge and couple it with your clinical knowledge, apply it to determining the financial risk of a potentially catastrophic case for your employer, and then communicate that risk to your employer, you will be viewed as an invaluable asset," she says.

Your employer can use the information to set more appropriate financial reserves based on claims expenses that are incurred but not reported.

"Setting appropriate financial reserves affects the overall profitability of the organization in which a case manager works. This results in the company's ability to have operating capital allocated to other departments rather than being set aside in reserves, a possible reduction in overall claims experience, and thus the potential for a better rating that affects many premium levels, including both insurance and reinsurance premiums, Milne says.

Two scenarios

Case managers need to be able to look at an individual case, understand the resources that the specific treatment (past, current, and future) will involve for this particular case, and pull together an appropriate cost analysis, Milne says.

Here are two scenarios, cited by Milne, in which a case manager's expertise can have an impact on his or her organization's finances.

If you have a heart patient whose condition is stable at present but, due to your clinical expertise and assessment skills, you know he or she is likely to end up needing a heart transplant in the very near future, you can go to your organization's chief financial officer (CFO) and make sure he or she is aware of the case and the potential costs involved. The CFO can use the information to make sure there are enough dollars allocated in the reserves to cover the costs if he or she does have to have a transplant. Then, when the claim comes in, there are no surprises that could result in a real financial disaster for your organization.

The CFO at your organization may project that the care for a critically ill patient is going to cost $500,000 next year. If you know this case, know what costs have been incurred, what treatment the patient will need, what the cost will be, and it doesn't add up to the projected $500,000, you can, and should, present your information, showing

the care isn't going to cost that much, which will free up the money in the reserves and make the overall claims experience look better.

An actuary often works with the CFO to predict costs for a specific population based on demographics. However, the actuary cannot use those models to accurately predict the high-dollar, low-frequency cases, such as the ones mentioned above, Milne says. Those cases are hit or miss for actuaries.

"If a case manager could get into the financial discussions and offer his or her input on what is actually happening with the patients, the company could make more accurate reserves," Milne says.

Focus on the cases that are extensive in nature, expensive and/or unusual, or both, cases that will hit hard on the company's bottom line, Milne suggests.

Among these would be transplants, high-risk pregnancies and preemies below 28 weeks gestation or above 28 weeks with congenital deformities, lymphomas, leukemia, and stage 3 or stage 4 solid tumors, complicated cardiac cases, traumatic injuries, and rare disease or disorders, such as hemophilia.

When you encounter one of these cases, make sure to provide the management in your organization the information it needs to appropriately set reserves.

If you can't communicate directly with management, make sure your supervisor knows what's gone on and shares the information.

Tying yourself closer to the administration and financial people in the organization for which you work can only be to your benefit.

"When it comes time to cut back, often case management is first on the chopping block. But if you have been able to identify several cases that were going to have a financial impact on your organization — whether it was positive or negative — the upper management will think twice about eliminating your job," Milne says. ■

Rely on past experience in project cost of care

Networking can help you fill in the gaps

A case manager's past experience and knowledge are invaluable when projecting the cost of care, says **Joann Milne**, RN, BSN, CRRN, PHN.

"The real key is not to be afraid to project the cost of care and to get as accurate as you can. Often, for case managers, their years of experience give them the ability to get very close to actual claims when they do their cost projections, says Milne, assistant vice president of medical management programs with IOA Re, with headquarters in Plymouth Meeting, PA.

Look at the type of care and how complex it is. Take into account the complexity of the individual and the length and type of care that particular person will require.

Know what your company's risk exposure is. What is the contract period? What services are covered? Is there a reinsurer, and when does it kick in?

For instance, if you assume care of a 9-month-old with a hypoplastic left heart in November, and the contract period runs January to December, you need to project the cost of care from the date of birth to the end of December, and then for the next 12 months.

Take the cost of past care into account. Typically, by the time a case manager gets involved, the patient already has received care. Talk with the claims examiner to determine what claims have been paid to date.

Look at whether care is being done in-network or out of network. This information usually is available from your supervisor or from the contract manager. Know if your provider contracts call for care on a per-diem basis or if the company is being billed for a percentage off the charges. Consider what treatment/procedures still need to be done for the patient to obtain a state of wellness.

Review your cost projections regularly. If you see something that has changed, make sure the administration knows that the costs are expected to go up or down and by what amount.

"Cost projection is very fluid," she adds.

Network with other case managers to share information on the anticipated clinical course of the disease or condition, average length of stay, and outcomes.

Disease management companies are excellent resources and can give you information on projected clinical courses and average costs.

Look within your organization for resources. For instance, the claims staff and medical directors have a good grasp of the cost of care. Your financing and contracting department also are good resources. MillimanUSA (formerly Milliman

and Robertson) publications are another good source for information. The Redbook provides valuable information to help you determine the cost of pharmaceuticals. ■

Managing mental health along with medical care

Separate departments join forces to coordinate care

Coordinating the case management for mental health problems with medical case management has paid off for a Medicaid managed care organization.

HealthSource/Hudson Health plan in Tarrytown, NY, has the highest scores in the state in two of three quality indicators for mental health services monitored by the New York State Department of Health. The organization does not have enough members to qualify for the third indicator.

"Our ability to score so high on quality indicators for the state has everything to do with the medical case management and mental health care management working together," says **Margaret Leonard**, MS, RN, CFNP, Cm, vice president of clinical services for HealthSource/Hudson Health Plan.

HealthSource is a not-for-profit managed care organization of 37,000 members covered under Medicaid, Child Health Plus, and Family Health Plus. The company was one of the first prepaid health services that came into play under a waiver allowing Medicaid managed care.

When Leonard and her staff examined the reports coming from the state and compared utilization visits and costs, they realized that HealthSource was above the statewide average for utilization for substance abuse and other mental health visits.

"We questioned why it was happening and — if we were doing case management — if we were just authorizing the care and not actually managing the care and getting a better understanding of why the visits were needed," she says.

That's when they began looking at ways to manage the care of their mental health clients.

"We were well known for our mental health outreach and for the care and referrals we were doing for mental health patients, but we weren't looking at any utilization data at all. HealthSource was really known as the gold card for mental health services," Leonard says.

After looking at a number of options, the company contracted with Boston-based Beacon Health Strategies to handle the case management and utilization review for its Medicaid managed care mental health services.

"We interviewed vendors and chose one that had the same philosophy and mission as we had and which shared our core values," Leonard says.

The impetus for the new system was not to reduce utilization but to find out why the patients were getting so many more visits than patients covered by other Medicaid managed care plans.

"We have reduced utilization while maintaining and exceeding our reputation in the mental health community," Leonard says.

HealthSource pays Beacon Health Strategies an administration fee for handling case management and utilization review.

"It's not a risk contract. We didn't want for our utilization to be managed with a profit-drive force behind it. We were looking for outcomes," she says.

Beacon set up an office on-site at HealthSource/Hudson Health Plan, hired existing staff, and brought in a new supervisor for the mental health department.

"Being on site helped us tremendously with interaction. We don't interact telephonically. Our medical case managers and mental health care managers can walk over and discuss a patient," she says.

The case managers who handle the Medicaid patient's medical care are employed by HealthSource. The mental health case managers are employed by the contractor, Beacon Health Strategies of Boston, but are physically located at HealthSource.

The two entities have arranged to share their databases so the nurses have access but with confidentiality issues covered.

"All case managers can view the patients' mental health status and access to care as well as physical health care," she adds.

The partners created an internal referral system so that patients who need the services of both the physical health and mental health providers can get the care they need.

For instance, if the mental health people have a patient who is a substance abuser, an alcoholic, a heavy smoker, or suffering from depression and they find out she's pregnant, they refer her to the

medical side and discuss her case with the maternity care case managers.

"In the same way, we may look at a patient and realize that something isn't happening that needs to happen and refer them over to mental health people," Leonard says.

"Through the right channels of confidentiality, we can collaborate to get a health outcome for the patient," she says.

The plan's biggest challenge came in 1999, when Medicaid recipients who receive social security benefits had to choose a managed care plan.

The people covered under the mandate are those who receive social security benefits because a disability prevents them from working.

HealthSource's mandatory SSI enrollees are enrolled for medical benefits, but their mental health benefits are carved out and the services they get are being billed to Medicaid directly. HealthSource is reimbursed for those members' medical health costs at a capitated per-member per-month rate.

For mental health services, the clients take their Medicaid card to the provider of their choosing. The provider bills the state directly under Medicaid's fee for service.

"We know that at least 40% of them have a mental health diagnosis that makes them eligible for this benefit. We felt that we needed to do some kind of management on the mental health side, even though we are not paying for it or being reimbursed by the state," Leonard says.

Often, clients with mental problems exacerbate their physical health problems because of substance abuse or because their mental state makes it difficult for them to cope with the challenges of seeking care.

"The challenge is that we pay for their medical health, and a lot of time their medical health is impacted greatly by their mental health but we are out of the loop. We can't tell them not to go to a certain mental health provider because it's not in the network. But if they are in our case management system and we can find out where they are going for care, we can help coordinate their care even if we aren't paying for it," Leonard says

Because HealthSource has mental health case managers on site, it is able to identify the people who needed mental health referrals and work with the community resources that could provide help.

"Preventative care is the biggest challenge in this population where services are being carved out, but we are still responsible for the whole person. People who need care often can't handle the pressure for getting care," Leonard says.

HealthSource's internal system helps the case managers connect people to the right system, and the organization's rapport with providers in the community helps them coordinate care with their medical case management clients who seek mental health services.

"Because we have a relationship with providers, they will notify us when someone is getting services, even though we're not paying for it," she says. ■

Six ways to coordinate your mental, medical services

1. If you decide to choose a vendor for your mental health case management, make sure the vendor's philosophy is the same as yours.
2. Understand the benefits and challenges of any kind of partnership.
3. Realize that you are going to have to make an investment of time and money in the endeavor.
4. Set up a way to share information between the two entities.
5. Make sure your information technology staff are involved to ensure that patient confidentiality is protected.
6. Track and analyze your utilization data.

Include psychological evaluation in initial rehab

Deal with problems sooner, rather than later

You've probably had clients with traumatic injuries or illnesses who just didn't get better during the rehabilitation process — even when there was no physical reason for it.

When patients fail to make progress even though the physical evidence says they should, there may be underlying psychological issues, says **Laurence Miller**, PhD, director of psychological services for Heartland Pain and Rehabilitation in Lantana, FL.

"Case managers will call for a psychological assessment as a last resort, when the patient isn't progressing and they're pulling their hair out and can't figure out why the patient isn't

getting better," Miller says.

But it's quicker and cheaper to deal with the problems early on, he adds.

"Studies and research have found that the inclusion of psychological management in any type of rehabilitation ends up costing less in the long run," Miller adds.

Most payers don't routinely include psychological components in their treatment, but from the standpoint of patient care and expense reduction, it's cheaper up front, he says.

He recommends a baseline psychological evaluation as part of any treatment plan to determine if the patient could benefit from psychological services, biofeedback, or behavior modification.

"The less time since the injury, the smaller problems you'll see. If you wait until later, you'll have a firmly entrenched professional patient who is dejected and demoralized, and they can be much harder to treat and tough to handle," he adds.

Laurence recommends a psychological component in the rehabilitation treatment plans for all patients rather than waiting until the last minute.

"I don't believe everybody has to have extensive psychological treatment, but they should have an upfront psychological evaluation to see what role psychology can play in their recovery," Miller adds.

Whether a patient is experiencing chronic pain from a herniated disk or is recovering from a stroke or a spinal cord injury, he or she can expect to return to some semblance of stability within the first six months, Miller says.

"If at six months a patient is continuing to experience severe problems that can't be traced to a physical cause, ask the primary care or secondary care provider what is going on," he advises.

When you read the reports on the patients, look for indicators such as "the patient is not exerting maximum effort" or "the patient is not meeting his goals," Miller adds.

Physicians don't always understand the nuances in psychological disorders. They may not know if the patient is malingering or if the symptoms are psychological, he says. That's why it's important that the patient's psychological function be evaluated by someone with mental health expertise.

If you refer a patient for a psychological evaluation, call it stress management, not psychotherapy, Miller advises.

"But if they are resistant to it, it's not something you can force down their throats," he adds.

There are a number of reasons why patients fail to get better when all the medical evidence says they should. They may be depressed and lack the will and motivation to meet their goals, or they may not have a clear goal in mind. In some cases, the providers may set the goals too high for patients to meet, setting them up for failure, which further demoralizes them and stops their motivation.

Or they may have a hidden agenda that impedes progress. For instance, a workers' compensation patient may be anticipating a large financial settlement. A patient may be angry at the system because she got hurt at work and the only way to get back at her boss or the job is to remain impaired. Or, a patient may subconsciously enjoy being in a dependent role that allows him to manipulate other people.

When patients aren't getting better to the extent that you think they should, make an assessment and decide if it's related to the injury, or to psychological aspects, such as the family or the larger social situation, Miller says. ■

Nursing home info available to the public

Consumers in six states now have access to comparative quality data about nursing homes. It is part of a pilot project that will be rolled out nationally by October.

For now, consumers in Colorado, Florida, Maryland, Ohio, Rhode Island, and Washington state will have information on data including: use of restraints, bedsores, infections, pain management, and use of anti-psychotic medications.

PRO-West, a Seattle-based nonprofit health care quality improvement organization, will collect the data, which also will include information on pneumonia, respiratory infection, septicemia, urinary tract infection, viral hepatitis, wound infection, fever, and recurrent lung aspiration.

Currently, only 20 states publish nursing home quality data. The new data will be available on the Medicare web site at www.medicare.gov. ▼

AHRQ's releases 1998, 1999 hospital statistics

The federal Agency for Healthcare Research and Quality (AHRQ) released 1998 and 1999 hospital inpatient data for the country, regions, and selected states this month. For the first time, it also includes statistics from the Kids' Inpatient Database — the only hospital administrative data set specifically designed for analyzing the use of hospital services by newborns, children, and adolescents. HCUPnet enables users to identify, track, analyze, and compare statistics on the inpatient care of Americans.

Since its launch two years ago, the tool has provided answers to thousands of questions about hospital care, including the leading reasons for admission, the most expensive surgical procedures, the proportion of stays for diabetes that are covered by Medicaid, the proportion of children's stays that are not covered by insurance, and the trend in the number of coronary artery bypass grafts over the past several years.

AHRQ also announced three further upgrades to HCUPnet. These are:

- Instant Tables — commonly requested statistics users can obtain instantly without having to go through HCUPnet's query system.

CE questions

Please use the enclosed Scantron to submit your answers for the January-June 2002 CE test and return the Scantron and CE/CME Survey in the envelope.

21. Which of the following is not one of the three categories of HIPAA regulations?
    A. transaction standards
    B. security standards
    C. patient safety standards
    D. privacy regulations

22. Job-retraining agencies generally are not covered by HIPAA, as they do not provide health care services.
    A. true
    B. false

23. List the second step to a cost-benefit analysis.
    A. Compare the various options and their cost and outcome.
    B. Identify the treatment options.
    C. Add documentation about anticipated outcomes and what the ultimate goal is.
    D. Come up with the cost of each option.

24. Which of the following are ways to coordinate your mental and medical services?
    A. Understand the benefits and challenges of any kind of partnership.
    B. Set up a way to share information between the two entities.
    C. Track and analyze your utilization data.
    D. All of the above

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Editorial Questions

Questions or comments? Call **Mary Booth Thomas** at (770) 934-1440.

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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.

Please save your monthly issues with the CE/CME questions in order to take the two semester tests in June and December. A Scantron form will be inserted in those issues, but the questions will not be repeated. ■

• The National Bill — quick access to aggregate charges for diagnoses and procedures, telling users the total national bill for specific diagnoses and procedures.

• The ability to specify ranges of ICD-9-CM codes instead of having to request each ICD-9-CM code individually.

The National estimates used in HCUPnet are based on data from the Nationwide Inpatient Sample (NIS).

The 1998 and 1999 NIS data are available on CD-ROM with accompanying documentation for $160 each from the National Technical Information Service at (800) 553-6847 or (703) 605-6000. The 1998 NIS product number is PB2001-500092, and the 1999 NIS product number is PB2002-500020. ■

Reports From the Field™

Lack of awareness impairs stroke treatment

Clot-busting underutilized

People at high risk for stroke need a more structured stroke education and prevention program, researchers at the Mayo Clinic have concluded.

Clot-busting for acute stroke victims may be underutilized because of poor recognition of stroke symptoms and inadequate knowledge of acute treatment options, the researchers say.

While the majority of respondents to a random survey recognized paralysis as a symptom of stroke, other symptoms, such as the inability to articulate thoughts into words, visual loss, and numbing and tingling were far less commonly recognized.

"We were surprised to find virtually no difference in knowledge of symptoms or treatment between those with stroke risk factors and those without," says study author **Kelly Flemming**, MD.

Thrombolytic therapy critical

Nearly two thirds of the respondents did not know about treatment options or the urgency of administering therapy, and less than half said they would call 911 if they thought they were having a stroke.

The researchers called on all health care providers to improve their stroke education programs, including stroke prevention, presenting symptoms, treatment options, and what to do if the symptoms occur.

"Thrombolytic therapy can be critical to the subsequent quality of life for stroke victims and, while stroke prevention education may be most helpful overall, education about the urgency of stroke treatment is perhaps the most important in the event of a stroke," Flemming says.

The researcher reported the results of their survey at the American Academy of Neurology's 54th Annual Meeting. For more information, visit the American Academy of Neurology's web site at www.aan.com. ▼

Most effective asthma drug not most often prescribed

Insurance claims analyzed

The most effective and intensive medication treatment for asthma is not the drug most commonly prescribed for the condition, a new study has found.

Researchers at Ohio State University (OSU) analyzed 18 months of insurance claims for asthma medications and concluded that the most effective of the medications cost two to three times less than the more frequently prescribed medications.

Results of the study, sponsored by GlaxoSmithKline as part of an internship project in pharmacoeconomics at OSU, was published in the April issue of *Pharmacotherapy*.[1]

Patients who take the asthma drug fluticasone propionate (sold under the brand name Flovent) had fewer hospitalizations, fewer trips to the emergency department, and needed less

medication to help control the symptoms than patients taking two other drugs, the researchers concluded.

Fluticasone propionate, an inhaled cortiosteroid, was compared to montelukast (Singulair) and zafirlukast (Accolate). The other two drugs are leukotriene receptor blockers in tablet form that help decrease the inflammation.

"These findings confirm what clinical trials have already shown. While doctors have to decide what's best for their patients, we're not sure why, given its effectiveness, fluticasone propionate is not prescribed more often as the first step in treating mild asthma," says **Dev Pathak**, DBA, study co-author and professor of pharmacy at OSU.

The researchers collected claims data from 781 patients covered by four nationwide managed care plans. The average cost for patients using fluticasone propionate was $528 for nine months. For patients using montelukast, the cost was $967.

For zafirlukast it was $1,359. Costs include filling prescriptions, trips to physicians' offices and emergency departments, hospitalizations, and prescriptions for additional medicine for asthma symptoms.

Reference

1. Pathak D; Davis A, Stanford R. Economic Impact of Asthma Therapy with Fluticasone Propionate, Montelukast or Zafirlukast in a Managed Care Population. *Pharmacotherapy*:2002; 22:166-174.. ▼

Experienced hospitals a better choice for seniors' surgery

Death rates lower at high-volume hospitals

Older patients who face high-risk surgery, such as cardiovascular or cancer operations, are more likely to survive if they go to a hospital that is highly experienced with their particular procedure, according to a new study.

The research, sponsored by the Agency for Healthcare Research and Quality (AHRQ) compared elderly patients who had any of 14 high-risk operations in hospitals that performed a high volume of the procedure with those at a hospital where only a few of the procedures were informed.

Each year, more than 20,000 elderly patients die undergoing one of the high-risk operations studied. More than 1,000 of these death could be averted if the patients at the lowest volume hospitals had surgery at the higher volume hospitals, concluded **John D. Birkmeyer**, MD, associated professor of surgery at Dartmouth Medical School in Hanover, NH, and a general surgeon at Dartmouth-Hitchcock Medical Center, lead researcher for the study.

The differences were most dramatic for patients undergoing surgery for cancer of the pancreas. Only 4% of patient at the highest-volume hospitals died compared to 16% at the lowest volume hospitals. Death rates for patients having surgery for cancer of the esophagus were 8% at the highest volume hospitals compared to 20% at the lowest volume ones.

Death rates were between 2% and 5% lower at high-volume hospitals for patients undergoing heart valve replacement, abdominal aneurysm repair, and surgery for lung, stomach, or bladder cancer.

The researchers concluded that hospital volume was less important for patients undergoing coronary artery surgery, carotid endarterectomy, and surgery for colon or kidney cancer.

The study examined outcomes in 2.5 million Medicare patients who had surgery between 1994 and 1991 and focused on total hospital volume, not Medicare volume.

Related article:

• Birkmeyer J, Siewers A, Finlayson E, et al: Hospital Volume and Surgical Mortality in the United States. *NEJM*, 2002; 346:1,128-1,137. ■

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If you have a new resource, conference, or seminar that can help other case managers do their jobs better or more efficiently, *Case Management Advisor* wants to hear from you.

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