AMERICAN HEALTH CONSULTANTS®

HOSPITAL CASE MANAGEMENT™

the monthly update on hospital-based care planning and critical paths

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Transfer provision costing millions, study confirms

Provision forces hospitals to operate efficiently

A government study says that although hospitals are losing money on the new transfer provision of the proposed prospective payment system (PPS), most hospitals are not circumventing the rule by compromising patient care or keeping patients longer than medically necessary.

The new transfer rule, which went into effect Oct. 1, 1998, affects Medicare patients in 10 diagnosis-related groups (DRGs) that were selected based on their high volume of discharges to postacute care, according to the Baltimore-based Health Care Financing Administration (HCFA). The Clinton administration placed a moratorium on expanding the number of DRGs affected by the rule until fiscal year 2003.

In its study, released in the May 5, 2000, *Federal Register*, HCFA says the provision resulted in an average profit of $1,180, with the average margin for DRG 483 (tracheotomy, the most expensive of the 10 DRGs) declining to $16,672 per case in fiscal year 1999. Before the change, profits ranged from $32,007 per case for DRG 483 to -$26 per case for DRG 211 (hip and femur procedures, the only one of the 10 DRGs with a negative profit margin before implementation of the policy). HCFA commissioned Waltham, MA-based Health Economics Research Inc. (HER) to conduct the study, which is intended to provide information to Congress and the general public. It does not include recommended policy changes.

The Chicago-based American Hospital Association (AHS) says the rule should be repealed because

it unfairly penalizes hospitals with shorter-than-average lengths of stay (LOS) and will cost hospitals $1 billion in 1999 and 2000.

But **Stuart Guterman**, principal research associate at the Urban Institute in Washington, DC, and a former deputy director of the Medicare Payment Advisory Commission, says the provision is appropriate because Medicare payments for the 10 DRGs are now more in line with hospitals' costs. Guterman says HER's research proves the transfer provision hasn't affected hospitals' ability to make money. Adding the other, less profitable DRGs to the provision list likely would not have a great impact on hospitals, he maintains.

"We've already gotten the most bang for the buck," Guterman says. "In terms of policy, it makes sense to apply the provision to all DRGs. I don't see the rationale of applying this policy to 10 DRGs and not to all of them."

Deborah Hale, president of Administrative Consultant Services in Shawnee, OK, disagrees. She says HCFA's incentive in developing the rules in the first place was to encourage hospitals to operate more efficiently and effectively. "I think hospitals feel discouraged when, every time they respond to a government incentive to improve efficiency and effectiveness, the end result is payment reduction. That's what they've done in the past every time we've responded. It's like we've responded too well, so now we are going to be penalized."

Hospitals have taken their share of cuts and have become more resilient and efficient as a result, says **Aileen Day**, director of medical management at North Shore Medical Center in Lynn, MA. "The question is, 'How much can we survive in hospitals? How many decreases in reimbursement can we survive?' I think that what we are seeing is that some places have not been able to survive some of these changes and have closed," she says.

Guterman, however, says the real issue is defining Medicare's role. "Hospitals have been hurt because they are not making as much money as they used to on Medicare, and they were relying on Medicare profits to offset the losses on other services. They have pressure from HMOs, they have pressure from uncompensated care that they treat, and they were relying on Medicare payments to offset some of their losses."

For the 10 DRGs included in HCFA's expanded transfer definition, a hospital receives less than the full DRG payment when a patient is discharged more than one day before the average length of stay for the DRG and is referred to a home health agency within three days of discharge from the hospital or is discharged to a rehabilitation or other PPS-exempt facility or skilled nursing facility. In the past, hospitals received the full Medicare DRG payment regardless of LOS. Payments for cases with shorter-than-average stays helped defray the costs of caring for patients with longer-than-average stays.

The DRGs included in the definition account for about 10% of all inpatient cases. Because of this impact, the AHA supports the Medicare Common Sense Hospital Payment Act, legislation that would repeal the transfer provision.

Not only does the provision penalize hospitals that have worked to reduce their LOS; it also restricts access to coordinated patient care, creates administrative problems, and puts hospitals at risk, according to a statement released by the AHA.

Switching from skilled nursing to swing beds

Hale says the losses have resulted in some hospitals being forced to close home health services or skilled nursing units. "It's been kind of a combination of the change in the transfer definition and cuts in reimbursement with the RUG [Resource Utilization Group] payment for the skilled units. You put those two together, and a lot of hospitals are just not finding it feasible to continue their skilled units," she notes. "I've known several that had distinct-part skilled units that closed those and used their opportunity to have a swing bed service because the swing bed was exempt. A swing bed is still reimbursed at cost, and there is more of a financial incentive to do that.

"Whether that trend continues in the future may depend upon whether the transfer definition extends to swing beds and whether the RUG payment extends to swing beds. When that happens, then that possibility will be gone as well," Hale says.

While preliminary results of HER's report show the new policy has not affected patient care, it also suggests there is some evidence, albeit inconclusive, that at least some hospitals are keeping patients in the 10 DRGs longer prior to transfer in order to capture the entire DRG.

The study compared the first two quarters of 1998 and 1999 and found that the mean LOS of short-stay postacute transfers was fairly constant

prior to the change. After the change, the mean LOS of short-stay postacute transfers declined less than 0.5%.

However, the study found that the average LOS in cases not affected by the provision dropped 1.8%, while cases that were affected remained the same. "[HER] draws the conclusion that hospitals must be treating transfers differently, because the group affected by the provision would have been impacted the way the non-affected group was. There are a lot of reasons that could be true, and it could have nothing to do with hospital behavior," says Guterman. "You don't know what the reasons are without spending a lot of money. But you can just observe what happened to these cases compared to other cases."

However, the comparison of short-stay postacute transfers relative to all short-stay cases determined that percentages fell from 59% in 1998 to 58% in 1999, which led HER to determine that "the policy change resulted in a moderate decline in the number of postacute care transfers paid for under the lower per diem methodology."

Hale says before the transfer definition was changed, hospitals had an incentive to move patients through the system as quickly as possible. "I think [after the rule change] maybe some of them intended to slow down and not push so hard and not be fraudulent. They actually just didn't find the time to focus on that. They didn't find the time to get the information to the discharge planners, for example. Often the discharge planners have no idea what DRG that patient is in, and they are not looking at it from the perspective of, 'How much money are we going to lose?' They are actually looking at it from the perspective of, 'What is best for the patient?'

"Obviously, the change in transfer definition causes you to get less reimbursement," she says. "But for the most part, the hospitals that I'm aware of are just doing what is best for the patient and not looking at it from a financial perspective."

Day says although the provision is affecting her hospital financially, "We take care of the patient and the patient's well-being. We try to have them go where they need to be to get the care that they need. But we are tracking [the transfers] more and it has affected the reimbursement."

On the positive side for hospitals, HCFA, and the transfer rule, HER concluded that hospitals are improving the accuracy of coding transfer cases.

In 1998, only 74% of transfer cases had discharge destination codes on the acute care hospital claim that were consistent with whether there was a postacute care claim for the case matching the date of discharge. Following implementation, the rate rose to 79%.

Accurate coding requires more follow-up

"I think hospitals did work a little harder to report discharge destination codes accurately, but it really puts a burden on the hospital to follow up to see if a patient received home health services within three days of discharge," Hale says. "Sometimes a patient refuses services in a hospital, so it is documented in the discharge plan that there's no need. Then later the family calls the physician, and the person is not handling the situation as well as we'd thought. That puts the hospital in the position of having to call these patients to find out [how they are coping]. To me, that's a lot of added regulatory burden, but that's the extent to which hospitals were willing to go in order to demonstrate their intent to be compliant," Hale said.

To assess whether postacute care was being delayed, HER considered the number and percentage of cases admitted to either a hospital or distinct-part unit of a hospital excluded from the prospective payment system or to a SNF two or three days following the discharge, and the number and percentage of patients who received services from a home health agency four or five days after discharge from an acute care hospital.

The analysis found that home health referral on the fourth or fifth day following discharge fell from 17.5% to 16.5% between the two study periods. On the basis of these findings, HER says "these results do not support the contention that hospitals would circumvent the lower per diem payments by delaying the date of postacute care admission or visit."

The role of the hospital in the continuum of care has been changing over time as trends have shown patients being discharged earlier to skilled nursing facilities, home health facilities, and rehab hospitals, says Guterman. "There's nothing wrong with that. It could reflect a more efficient way of treating patients.

"As soon as [a patient] is no longer in need of acute care, you get them out of the hospital and put them into a different setting," Guterman says. "It does mean that the cost of the hospital stay is changing, partially because the nature of the hospital stay is changing."

And as the nature of hospitals changes, so do the payment rules. "[Under the old rules] hospitals were getting the full DRG amount for cases they were transferring to another facility," Guterman says.

But, as Hale points out, because of hospitals' financial woes, alternative levels of care are increasingly being provided within acute care facilities.

For more information, contact:

The American Hospital Association, Chicago. Telephone: (312) 422-3000.

Stuart Guterman, principal research associate, the Urban Institute, Washington, DC. Telephone: (202) 833-5561.

Deborah Hale, president, Administrative Consultant Services, Shawnee, OK. Telephone: (405) 878-0118.

Aileen Day, director of medical management, North Shore Medical Center, Lynn, MA. Telephone: (781) 581-9200. ■

Reader survey: CMs remain dedicated to field

Survey shows case managers are satisfied

Nearly 70% of hospital case managers responding to a recent survey conducted by *Hospital Case Management* report little or no opportunity for growth in their current facility. Despite what would be considered a bleak future in other fields, 57% of respondents intend to remain in their current position indefinitely. Only 10% say they would leave now, while 62% say they will work in case management as long as positions are available.

If those figures don't prove case managers are committed to their careers, consider that 38% of respondents are satisfied with their jobs and 50% are somewhat satisfied. Only .7% are "very dissatisfied" with their jobs.

"In what other job would that be the case?" asks **Sandra Lowery**, RN, BSN, CCM, CRRN, president of the Case Management Society of America and an independent case manager with CCMI Associates in Francestown, NH. "This is one of those jobs that I can't believe they pay me to do. It is that rewarding."

Her colleagues seem to agree, saying while there is some burnout associated with the position, their futures remain in case management.

"That's how satisfying the job is," says Lowery. "It provides an opportunity to apply what you have learned in an academic setting and have never been able to apply in a practice setting.

"I think because our future will require that health care and business be combined in terms of a conceptual framework, case management is a golden opportunity to be able to learn and apply business skills to health care."

Case managers perceive the profession as a challenging and rewarding field that gives them the opportunity to broaden their base of contacts and level of interactivity, rather than working exclusively with a hospital team.

And while there's a certain level of satisfaction in working with patients, families, physicians, and nursing staff, Lowery says much of the fulfillment comes from identifying a patient's needs, matching resources, and seeing the outcome.

"You look at the big picture in terms of continuum of care and the holistic approach," she says.

Denise Kress, MS, RNC, CRNN, director of case management at Winchester (MA) Hospital, says when she began her career as a nurse many years ago, the field was very different, but oddly enough, some of the tasks can be applied to case management today.

"Patients were admitted, assigned to a nurse, and the nurse took care of the patients for their entire stay," says Kress. "You developed the plan of care and you made sure on the off-shift that others were following through. You were the person the patient, the physician, the family — everybody — knew was responsible for that patient. It was a totally different level of satisfaction."

But because of managed care, cost reductions resulting from the Balanced Budget Act, a shortage of nurses, and a variety of other reasons, there's been a reduction in the number of licensed practitioners taking care of patients. Few facilities have been able to maintain primary care nursing, especially because more nurses' aides are providing primary care, so nurses aren't having contact with patients the way they used to. And caring for the patient is one element that attracts certain personalities to nursing.

"I think it is satisfying to be able to do something with the patients and their families, especially when you work with an elderly population," Kress said. "You are really able to hear what their needs, desires, and dreams are, and you try to see if you can set a safe or good plan that meets their needs and gets them what they want so they can reach their goals."

That's not to say that all case managers are nurses who have wanted to move on. However, in hospitals, case management does require nursing skills, and nurses are more likely to make the transformation. Generally, the reasons for the change are job dissatisfaction in clinical practice, long hours, the higher intensity of care required these days, and concerns of legal liability with increased caseloads, Lowery says.

Wearing beepers, working weekends

"They think they will work normal hours in case management, but we are finding that's not necessarily the case in hospitals," Lowery says. "Case managers are now starting to wear beepers and having to work weekends and after hours, so it isn't quite what it was — an 8-to-5 job."

According to the survey, 58% of *HCM* readers work 41 to 50 hours a week, while 20% work 51 to 60 hours each week. Regarding their workload, 33% of respondents said they handle 21 to 25 cases, 25% handle 16 to 20 cases, and 24% have 26 to 30 at any given time.

The bulk of respondents — almost 58% — earn between $40,000 to $60,000 a year, with 30% earning $40,000 to $50,000, and 27% earning $50,000 to $60,000. Nineteen percent of respondents say they earn $60,000 to $70,000 annually. **(Complete results from *HCM*'s annual salary survey will be available in the November 2000 issue.)**

"It appears that there is parity in salary levels, which is what we've found to be the case in hospitals," Lowery says. "If those folks went outside the hospital, they wouldn't make as much money, but salaries are going up because of supply and demand. Certified case managers in populated areas are in demand. They are definitely in a seller's market."

Regarding education and certification, Lowery says you don't have to be certified to practice, but you must practice to earn certification. She says it is rare for a hospital to require a master's degree, and in many cases a bachelor's degree is not required. According to the survey, 12.3% of respondents hold an associate's degree, LPN, or 2-3 year degree; 40.6% hold a bachelor's of nursing or RN; 29% have a master's degree; 2.9% have an advanced practice nursing degree; and 15.2% hold other degrees.

In terms of data, Lowery says all indicators show case management is a growing field.

"Everything we are seeing in terms of increased education programs, both academic and continuing, the growth in publications that support the practice, and the growth in the professional society show there is a future for case management," says Lowery.

For more information, contact:

Sandra L. Lowery, RN, BSN, CCM, CRRN, president, Case Management Society of America; independent case manager, CCMI Associates, Francestown, NH. Telephone: (603) 547-2245.

Denise Kress, MS, RNC, CRNN, director of case management, Winchester (MA) Hospital. Telephone: (781) 756-4760. ■

GUEST COLUMN

Find out what's causing unplanned admissions

Research shows the reasons why

By **Patrice Spath**, RHIT
Brown-Spath Associates
Forest Grove, OR

Hospitals have seen a tremendous increase in the number of surgical procedures performed in the outpatient setting. This change in practice has implications for patient care quality and hospital resource use. Does ambulatory surgery negatively affect quality? Are strict controls on resource use resulting in unexpected hospital inpatient admissions? Can hospital and medical staff control quality problems while improving utilization? Do case managers need to be involved in preadmission assessments of outpatient surgery patients?

The medical staff may routinely review admissions following outpatient surgery to identify potential quality problems. It is unlikely this type of subjective case-by-case assessment will yield significant findings. Overnight stay is usually the appropriate action because of intraoperative findings or the patient's postoperative clinical condition. Selective peer review of individual cases will not provide the information needed for trend and pattern analysis. A longitudinal criteria-based study is much more effective

at identifying practice patterns or organizational issues that are affecting unplanned admission rates.

By reviewing all inpatient admissions following ambulatory surgery, the medical staff and the institution can identify structural or practice variations that could adversely affect patient care quality, patient satisfaction, and resource use. In seeking an explanation for your hospital's ambulatory surgery inpatient admission rate, several factors must be considered:

- **patient or disease-related factors** such as socioeconomic class of patient population, age, patient comorbidities, and patient noncompliance;
- **organizational/management factors** such as lack of sufficient holding or observation beds, payer reimbursement policies, scheduling of ambulatory surgery, staffing problems, unavailability of necessary equipment, and availability of psychosocial resources;
- **practitioner or staff-related factors** such as adequacy of preoperative assessment, availability of case managers in the outpatient surgery area, medical management and judgement, surgeon's technical skills, and patient selection.

To undertake a study of the reasons for hospital admission following ambulatory surgery, the medical staff and affected hospital departments must identify the data elements to be collected and the definitions. Some of the data elements that require further clarification include:

- **Admission following ambulatory surgery.**

Will the study include only patients admitted to the ambulatory surgery unit, or will it include patients admitted for any procedure in which they are expected to leave the hospital the same day, e.g., endoscopy patients seen only in the endoscopy lab, medical admissions for diagnostic procedures, etc.?

- **Post-procedure retention.**

Should a total hospital stay of less than 24 hours be deemed an unplanned admission if the patient stayed beyond the midnight hour? Or will the study only include those patients who stayed beyond 24 hours post-procedure? What about patients unexpectedly admitted as observation patients post-procedure? Are these patients counted as unplanned admissions? There are no right answers to these questions, but it's important to clarify the definitions before embarking on the study.

- **Reason for unplanned retention.**

During data collection, the reasons for the unplanned extended stay post-procedure will be gathered. These reasons can later be categorized for better analysis of the study results. For example, the reasons for extended stay can be broken down into five categories:

1. the number of patients who remained in the hospital for continued observation of post-surgical effects (noncomplications);
2. the number of patients who remained in the hospital for continued observation of perioperative complications;
3. the number of patients who remained in the hospital because of the need for more extensive surgery not anticipated at the time of admission for outpatient procedure;
4. the number of patients who remained in the hospital because of personal request (documented patient / family request for continued stay);
5. the number of patients who remained in the hospital for other reasons.

Collect additional information about the variables that might have affected post-procedure admissions, such as:

- preoperative American Society of Anesthesiologists (ASA) classification (a patient risk variable);
- type of anesthesia administered;
- surgeon / anesthesiologist;
- service (i.e., orthopedics, ophthalmology, etc.);
- patient age and payment source;
- patient's participation (or lack of participation) in preadmission education classes.

Data collection tool facilitates improvement

A data collection tool can be completed by unit nurses when patients are admitted following outpatient surgery. **(See data collection tool, p. 127.)** This tool also could be used by staff in the case management department or health information management department to conduct retrospective reviews.

By capturing well-defined and meaningful data about unplanned admissions following outpatient surgery, the medical staff and hospital departments can identify areas for potential improvement. Trends of admissions in certain services and inpatients receiving specific types of anesthesia may be overlooked when extended stays are only examined on a case-by-case basis.

It is important for hospitals to assess their post-ambulatory-surgery admission rates in these times

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CRITICAL PATH NETWORK™

Program overcomes barriers to staying healthy

Plan helps 500 physicians meet national standards

By **Debbie Togger**, MSN, RN
Quality Management Educator
Sharon Ross, MSN, CNP
Advanced Practice Nurse, Special Projects
St. John Medical Group, PC
Detroit

The Health Plan Employer Data and Information Set (HEDIS), a group of standardized measures used to evaluate the performance of managed care plans, was developed and implemented by the Washington, DC-based National Committee for Quality Assurance (NCQA), an independent organization that accredits managed care organizations and develops and disseminates information about the quality and performance of health maintenance organizations (HMOs). Most employer groups rely on HEDIS data to screen HMOs and make decisions about which plans to select for their employees. HEDIS helps employers and other consumers assess the value of their health care dollar, and it holds managed care plans accountable for their performance.

NCQA accreditation is voluntary now, but it may be required in the future. Plans to expand HEDIS criteria to include preferred provider organizations are currently under way. Some of the areas HEDIS evaluates are effectiveness of care (preventive screenings), use of services, and member satisfaction. HEDIS is relevant to hospitals that own physician practices because the HMOs with which hospitals contract would require the hospitals to ensure practices meet NCQA standards.

In many settings, managed care organizations (MCOs) offer physicians a financial reward for meeting certain thresholds for some of these indicators. For instance, the quality rating of the MCO for preventive screenings is dependent on the physicians who contract with them and provide care to members. When physicians are successful in getting their patients to obtain preventive screenings, everybody wins. The physician receives both a high quality rating and a financial reward, the MCO benefits with good preventive screening rates, and most importantly, the patient receives the screening tests that play a role in remaining healthy.

St. John HealthPartners in Detroit requested the assistance of the St. John Medical Group, PC (SJMG), in developing a comprehensive program to assist 500 physicians in their offices to meet HEDIS standards. For the past four years, a program has been in place to help physicians meet thresholds that result in financial reward, high quality rating, and benefits to the patient. SJMG focused on increasing the preventive screening rates for patients in need of Pap tests, mammograms, diabetic retinal screenings, and childhood immunizations.

Barriers to obtaining screenings included lack of notification and education of members about the need for screenings. Offices were not using every office visit as an opportunity to identify preventive screening needs. Another complicating factor arises when consulting or dual-choice physicians do not report their findings back to the primary care physician, who is ultimately responsible for ensuring preventive screenings have been performed. Primary care physicians also strongly felt that patient compliance was a barrier to achieving better screening rates.

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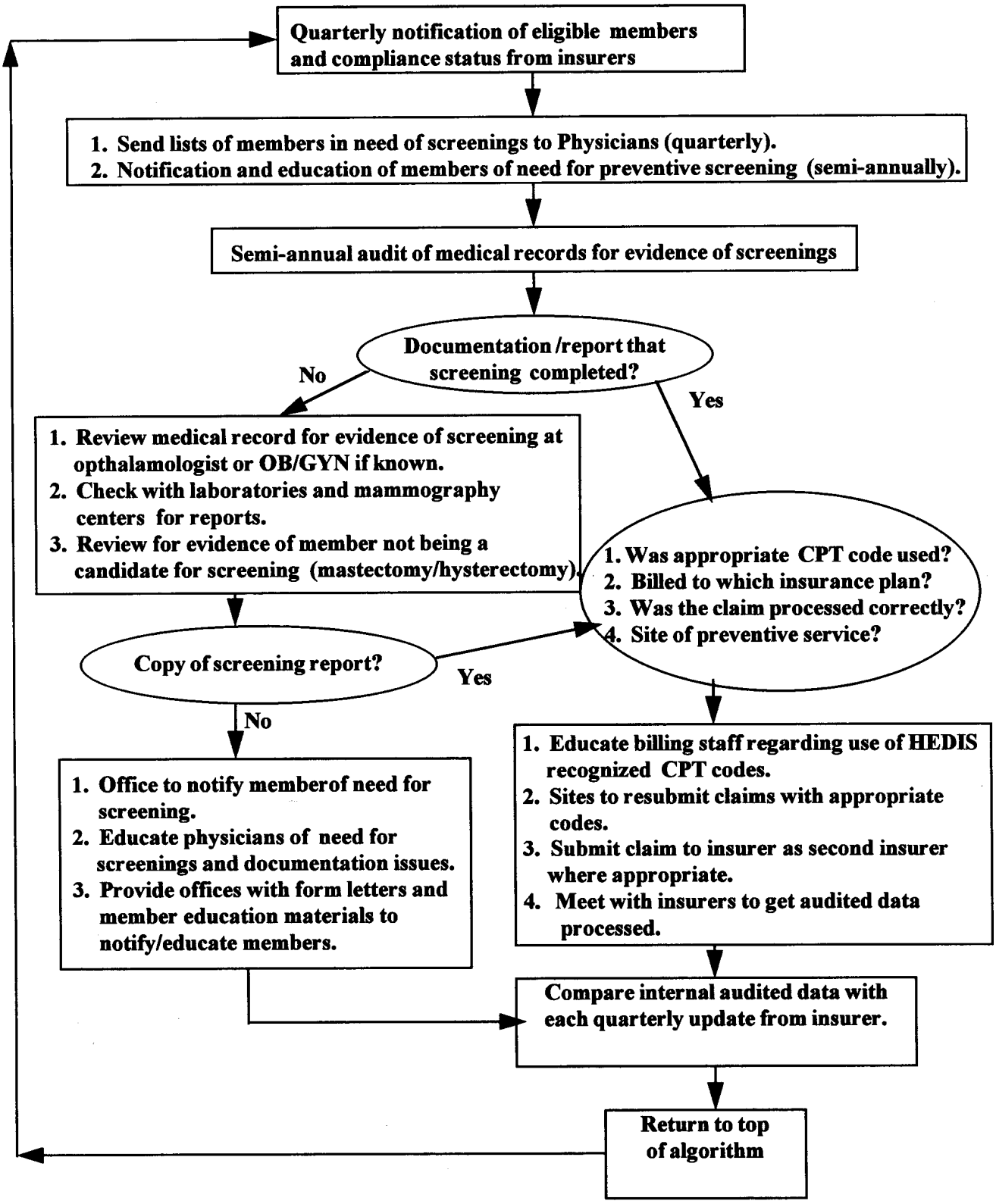
ST JOHN MEDICAL GROUP, PC

PROCESS OF IDENTIFYING COMPLIANCE WITH HEDIS STANDARDS



Source: St. John Medical Group, PC, Detroit.

Cervical Cancer

✓ **Cervical Cancer Facts:**

Cervical Cancer is the seventh most common cancer in American Women today. Cancer that is detected while still confined to the cervix is 100 percent curable.

✓ **Cervical Cancer Detection:**

Cervical Cancer is easily detected through a Pap (Papanicolaou) test. No symptoms tend to appear until the disease is well advanced. Such symptoms include vaginal bleeding or spotting frequently after intercourse. Pap tests should be performed regularly to detect abnormalities as early as possible.

✓ **Pap (Papanicolaou) Test:**

This test is usually performed during a pelvic exam in which a physician or other medical clinician uses a tiny spatula to scrape a sample of cells from the cervix. The cell scrapings are sent to a certified laboratory and observed closely for any cancer cells.

✓ **How to Schedule a Pap Test:**

Call your personal physician for an appointment. Most physicians can perform this procedure to obtain cervical cells in their office. You may also schedule this procedure through your gynecologist if you have one you see regularly. Follow up with your personal physician or gynecologist in two weeks for the results of the exam.

Source: St. John Medical Group, PC, Detroit.

(Continued from page 119)

SJMG has undertaken many activities to increase screening rates **(see process algorithm, p. 120)**. In the broadest sense, these activities can be divided into two categories: education and process issues. The education category consists of both physician and patient education.

Physician education was accomplished in several ways. First, designated physician leaders discussed the importance of addressing prevention in their practices at departmental meetings. The presentations consisted of an overview of HEDIS and the significance of HEDIS to the practicing physician. Designated leaders were selected based on knowledge of the topic and ability to relate to their peers.

Also, one-on-one education was provided in high-volume offices. Several topics were discussed during these individual meetings, including tips to achieve goals, processes to establish to get patients screened, and individual physician rates as compared to their peers. The review of individual physician compliance rates for these indicators as compared to their blinded peers was very effective in gaining physicians' attention.

To address patient education issues, SJMG sent patients a letter early in the year to notify them of the need for screening. The letter included screening education material. A second notification reminding them of the need for screening was sent out in late summer either in a different format or with an attached incentive. Incentives were developed through partnerships that were formed with a pharmaceutical firm and a nationally recognized cosmetic company.

In addition, a registered nurse made more than 400 phone calls to patients to encourage them to obtain screenings. An alliance also was forged with a local ophthalmology practice that phoned patients with diabetes to schedule a diabetic retinal exam. This proved to be a successful way to overcome the barrier of making an appointment. A similar process was established with a mammography center to assist patients in need of this exam.

Process issues in physician offices also were tackled. Office personnel were encouraged to develop a mechanism to identify all patients in need of preventive screenings, regardless of type of insurance, whenever the patient presented to the office for a sick or well appointment. This type of process reduces the incidence of missed opportunities to assess for the need for preventive services.

The insurer records patient compliance with preventive screening only if a claim for the service has been submitted using a billing code that is recognized by NCQA. Many patients who had the screening tests done were recorded as noncompliant by the insurance company because the codes that are NCQA-recognized are not always the ones billed by physician offices and hospital departments. For this reason, hundreds of chart audits were performed to capture as many compliant patients as possible. These audited data provided valuable information. If the insurer recorded a patient as being noncompliant, but a copy of the screening exam was obtained indicating the test was completed, follow-up was done to determine the reason that the claim was not picked up. Relationships were developed with the laboratory, mammography, and physician offices to bill these services using NCQA-recognized billing codes in order to increase compliance rates.

Lastly, SJMG staff are in constant communication with the insurers to discuss issues related to achievement of targets and goals. Meetings are scheduled on a regular basis throughout the year with high-level personnel to review ways to improve the program.

The final 1999 compliance rates have not been released. However, preliminary reports indicate that increases in compliance rates were achieved in at least three of the four indicators. In particular, a 17% increase has been observed in the rate of diabetic retinal screening from 1998 for members of one of the hospitals of St. John HealthPartners. It is our hope that through persistent efforts and constant vigilance, patients will become more educated, obtain their screenings, and remain healthy, which is the ultimate goal of both the insurer and the physician. ■

Share your pathway successes

Hospital Case Management welcomes guest columns about clinical path development and use. Articles should include any results (length of stay, cost, or process improvements) that use of your pathway has helped achieve and should be from 800 to 1,200 words long. Send article submissions to: Kimberly Coghill, editor, *Hospital Case Management*, P.O. Box 740056, Atlanta, GA 30374. Telephone: (404) 262-5537. ■

PATIENT EDUCATION
QUARTERLY

Patient/staff partnerships improve pain management

Education a must for JCAHO compliance

Pain has become a major focus of education since the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, added specific instructions to its standards this year. These instructions include appropriate assessment for pain and its cause and education of staff and patients on pain management.

The medical systems that already had pain management programs in place have simply had to tweak them to fit the standards. For example, in 1997, St. Francis Medical Center in Honolulu established standards for pain management that include education of patients and staff. They also added pain assessment into their patients' rights policy and incorporated pain as a fifth vital sign. The one improvement made since the standards were implemented is to focus more on how all disciplines assess for pain, rather than just focusing on nursing, says **Amy Krueger**, RN, MSN, FNPC, a nurse practitioner in pain management at St. Francis.

The Ohio State University Medical Center in Columbus had developed several education sheets on pain relief and had implemented a procedure for pain assessment, but a task force has now been assembled to make sure the medical facility has addressed all the issues covered in the standards.

"The task force is looking at process improvement initiatives on pain management, revising the pain assessment process, looking at pain management initiatives across the continuum of care, staff education in pain management, and producing pain management handouts specific to patient populations such as the elderly," says **Sandra Cornett**, RN, PhD, program manager for consumer health education at the medical center.

The Joint Commission standards on pain education and management are long overdue, says **Patricia Collins**, RN, MSN, clinical nurse specialist in oncology / pain at Baptist Health Systems of South Florida in Miami. While pain management and education were already addressed at this multihospital health care system, the standards provide an impetus to get every discipline on board. "When the standards came into place, it created more of an awareness and more of an urgency with getting everyone up to speed," says Collins.

While the standards are an incentive to fine-tune programs and spur people on to perfection, what do you do if you are starting from scratch? The institutions that had a framework in place before the standards were implemented are good examples for those institutions struggling to implement policies and procedures.

Most facilities have a system that establishes experts who can provide advice to clinicians on pain management. At The University of Texas MD Anderson Cancer Center in Houston, the Symptom Control & Palliative Care Center acts as a consultative service for both inpatient and outpatient areas. If a clinician diagnoses a patient as having pain, nausea, cachexia, or any symptom caused by cancer, the clinician can request a consult through this service, explains **Karen Stepan**, MPH, CHES, health education coordinator at MD Anderson.

Following a comprehensive interdisciplinary assessment, members of an interdisciplinary team work together to establish a plan of care that includes pain management. An institutional initiative is under way to include the Symptom Control & Palliative Care Center team as an integral component of all disease-specific clinical pathways. Upon clinician request, the team would provide a symptom assessment and overall plan of care for patients with advanced cancer.

To help clinicians on a routine basis, the Symptom Control & Palliative Care Center created cancer pain guidelines that provide a step-by-step decision making process on how to treat the type of pain the patient is having. The center also created a preprinted prescription pad that identifies pain treatment options based on severity of pain, says Stepan.

Baptist Health Systems has a Pain Resource Nurse (PRN) program in place systemwide and has trained 300 nurses to provide help with complex pain problems or patient education issues that may arise on the units. This program, which is patterned after a model created at City of Hope Cancer Center in Duarte, CA, also is used at St. Francis in Honolulu. "Those caring for the patient need resources readily available. We would like to have one PRN on each shift," says Krueger. St. Francis also has a pain management service that can be contacted for patient consultations. The team of experts includes nursing, physical therapy, spiritual services, social work, psychiatry, and neurology.

In addition to having a resource for expert advice on pain management, it is important to educate both staff and patients about pain and its assessment. "The biggest issue of pain management is the myths and misconceptions about it and proper assessment," says Krueger. Many clinicians were taught to look for behavior cues for pain, and now they must be taught to rely on what the patient tells them. Most patients at St. Francis are asked to assess their pain on a scale of one to 10, with one being very little or no pain and 10 being excruciating pain.

Patients as partners

"Patients must be taught that they are an important partner in their pain management," says Collins. To be effective partners, patients must understand how their pain will be assessed. That's why they are given a tip sheet upon admission to Baptist Health Systems that explains the importance of pain assessment and what questions they will be asked. For example, staff will want to know where patients' pain is located, what it feels like, how bad it is on a zero-to-10 scale, what helps their pain, what makes it worse, and how the pain interferes with their ability to eat and sleep.

To help patients better manage their pain, educational materials should be provided. When patients are admitted to St. Francis, they are given a patients' rights brochure that includes information about patients' right to receive pain assessment and management. They also receive a sheet titled "Talking About Your Pain" that reviews the pain assessment process. Handouts specific to the course of therapy also are available, such as cancer pain management or post-op pain management.

Patients who receive a consultation with an interdisciplinary team from the Symptom Control & Palliative Care Center at MD Anderson are given a medication record and a written and audiotaped version of their plan of care and question-and-answer period with the team. The patient can easily use the tape as a reference, explains Stepan.

Before creating a plan of care, the team completes a thorough assessment of the patient. Tools used to evaluate patients' pain include a symptom assessment that rates a patient's perception of pain, fatigue, nausea, depression, anxiety, drowsiness, shortness of breath, appetite, sleep, and feeling of well-being on a scale of zero to 10. Also used are a Mini-Mental State Examination to screen for cognitive impairment and a Cage Questionnaire used to assess the patient's coping mechanisms and the likelihood of a patient using chemicals to cope with stress.

The Mini-Mental State Assessment was developed by Marshal F. Folstein, MD, at Medford, MA-based Tufts University School of Medicine. The CAGE Questionnaire was developed by staff at Johns Hopkins University in Baltimore. Both assessments, along with instructions for their use, can be obtained from the Edmonton Palliative Care Program at the University of Alberta department of oncology (www.palliative.org).

To help complete the partnership, staff also must receive education on pain management. At St. Francis, in addition to a basic four-hour pain management class, staff can go on rounds with the pain management service once a week to discuss patients who are currently on the service and their pain etiology and treatment, says Krueger. Those who go on rounds can receive continuing education credits. **(For more information about pain etiology, see article on chronic pain management, p. 125.)**

A big issue for both patients and staff is the fear of addiction, says Collins. "Many patients think addiction and medication for pain go hand-in-hand. They don't understand that addiction is when people take pain medications for reasons other than pain. We spend a lot of time on this subject, and it is discussed on the patient tip sheet," she says. The topic also must be addressed in staff education.

Policies and procedures similar to the ones described in this article can easily be designed to fit your health care system and implemented in compliance with Joint Commission standards. "Our program has been in place for some time," says Krueger. "We have pretty much covered all the pain management standards, and it is not an overwhelming task to do so. The standards are very basic."

(Editor's note: The Joint Commission standards, including those on pain education and management, can be found on the Joint Commission Web site at: www.jcaho.org.)

For more information, contact:

Patricia Collins, RN, MSN, clinical nurse specialist in oncology/pain, Baptist Health Systems of South Florida, 6200 S.W. 73rd St., Miami, FL 33143. Telephone: (305) 662-8139. Fax: (305) 663-5092. E-mail: pcollins@bhssf.org.

Sandra Cornett, RN, PhD, program manager, consumer health education, department of consumer/corporate health education & wellness, The Ohio State University Medical Center, 1375 Perry St., 5th fl., Columbus, OH 43210. Telephone: (614) 293-3191. Fax: (614) 293-3690. E-mail: cornett.3@osu.edu.

Amy Krueger, RN, MSN, nurse practitioner pain management, St. Francis Medical Center, 2230 Liliha St., Honolulu, HI 96817. Telephone: (808) 547-6109. Fax: (808) 547-6292. E-mail: amyk@sfhs-hi.org.

Karen Stepan, MPH, CHES, health education coordinator, The University of Texas, MD Anderson Cancer Center, 1515 Holcomb Blvd., Box 21, Houston, TX 77095. Telephone: (713) 792-7128. Fax: (713) 794-5379. E-mail: kstepan@mdanderson.org. ■

Combine strategies to target chronic pain

Teaching self-management of chronic benign pain

Diabetic patients are taught to become active self-managers of their chronic condition, and that same concept can be applied to the management of chronic benign pain. At Kaiser Permanente Northern California in Oakland, a behaviorally based education program was developed to increase function so people with chronic pain can return to their normal activities of daily living. The program focuses on the physical, psychological, and social elements of pain management.

"Through the program, we try to move patients into an active self-management role of their chronic pain condition so that they feel they are in charge, instead of their chronic condition being in charge of them," explains **Andrew Bertagnolli**, PhD, chronic pain management program coordinator in the health education department of Kaiser Permanente Northern California.

Kaiser uses a multidisciplinary approach in its chronic benign pain management program. The team includes a physician to examine medication use and discuss the physical cause of pain and a health psychologist to address cognitive behavioral interventions for chronic pain, such as management of mood, assertiveness training, and cognitive reconditioning. Also included on the team are a physical therapist to address physical reconditioning and a nurse to handle the care management role.

Chronic pain is described in the literature as pain that lasts in duration for more than six months and well past the time a person would expect it to stop. With acute pain, there is a finite limit — the pain will end eventually — but with chronic benign pain, it will not. Chronic pain often has a snowball effect. The pain causes physical problems that begin to grow over time, leading to disruptions in mood, relationships, activities, and work functioning. "We may not be able to eliminate the physical source of the pain, but we can help people manage moods and other people and manage their activities," says Bertagnolli.

One of the main challenges of dealing with chronic benign pain is that it is subjective and varies from person to person. Its intensity is influenced by cultural, spiritual, and ethnic beliefs, and is also situational. "For some people, a prayer or meditation is going to be intuitively appealing based on their cultural background. For other people, that is not going to be part of a comprehensive pain management strategy," says **Arne Boudewyn**, PhD, chronic pain management program coordinator for Kaiser Permanente Northern California.

The program uses proven tactics such as management of mood, management of other people, management of activities, and behavioral reactivation. These topics and concepts are introduced to patients through a treatment group, and they learn to fit these concepts into their belief system.

For example, cognitive restructuring would focus on negative attitudes or unhelpful thinking. If a patient woke up in the morning with so much pain that he or she didn't want to get out of bed, the team would work with the patient to help him or her develop a more positive outlook. The team might encourage patients to think instead of how much better they would feel after getting up and doing a few stretching exercises. "We help them identify unhelpful thoughts or unhelpful thinking patterns and challenge them into developing more helpful strategies in terms of new thoughts," explains Bertagnolli.

Cognitive restructuring is an important element of the program. People with chronic benign pain need to identify unhelpful thinking styles and begin to develop more helpful thinking patterns if pain is to be controlled. Other elements of the program include developing a daily physical exercise regimen and daily relaxation exercises to prevent pain flare-ups.

To learn techniques and strategies that fit their treatment plan, patients participate in a group educational setting for eight to 10 weeks. The sessions run about two hours each week and offer a mix of education and application. A physical therapist might cover posture positioning to control pain. A physician may talk about the pros and cons of pain medication and how pain is communicated to the body. Each week, patients do homework in order to apply what they are learning.

The program helps participants overcome many barriers to pain management. In addition to negative thought processes, many people are fearful of doing anything that will exacerbate the pain. They are used to the acute pain model in which the pain signals that something is wrong. With chronic pain, the signal is still there, but there is no damage occurring.

Also, patients sometimes feel that the only answer is passive treatment, such as taking a medication or having a procedure. Yet, when they assess their pain on a scale of one to 10 and look back over time, they are able to see how some of the strategies of the program have reduced their pain. "Many feel that their pain is at a constant level and never varies, and that makes it unbearable. The scale shows them that it varies," says Bertagnolli.

The pain may be a nine one day and a seven the next because the patient went to a movie and was distracted, or the patient exercised or did something he or she enjoyed. Generally, most people who suffer from chronic pain cut out the pleasant activities first so they have the energy to do their chores. This can lead to depression.

"We want to shift them away from being a passive recipient to an active self-manager," says Bertagnolli.

For more information, contact Andrew Bertagnolli, PhD, chronic pain management program coordinator, or Arne Boudewyn, PhD, chronic pain management program coordinator, Kaiser Permanente Northern California, 1950 Franklin St., 13th fl., Oakland, CA 94612. Telephone: (510) 987-1301. Fax: (510) 873-5379. E-mail: Andrew.bertagnolli@kp.org or arne.boudewyn@kp.org. ■

Forms guide individualized discharge instruction

Categories prompt correct response in all areas

How are case managers handling the task of individualizing discharge instructions for each patient and maintaining a record of the individualized written instructions for the patient record in compliance with standards of the Joint Commission on Accreditation of Healthcare Organizations?

At Children's Healthcare of Atlanta, standardized discharge forms are usually used, with the forms individualized to each patient by writing the information in each table. For example, the instructions for a teenager going home on a clear liquid diet following surgery are different from a child with asthma going home on a regular diet.

The nurse writes in the discharge instructions per physician order. The family and nurse sign the form; one copy goes to the family, while the second is placed in the medical record.

In addition to the general discharge form, the health care system has created discharge teaching forms specific to certain patient populations, such as oncology. The template has information that is specific to that patient group, says **Kathy Ordelt**, RN, patient & family education coordinator at Children's Healthcare of Atlanta.

For example, the form might have information that instructs parents to call their child's physician if the child's temperature reaches 101 degrees. These forms also have boxes for individualized information. "The preprinted forms are for staff convenience to make it easier to capture all the information so it doesn't have to be written every single time," explains Ordelt.

No matter where the patient enters the health care system, including the emergency department, primary care setting, or inpatient setting, there is a discharge record that can be individualized. "They are formatted in a similar fashion, but they all contain different content that makes it appropriate for that clinical practice setting," says Ordelt.

For more information on individualized discharge instructions, contact Kathy Ordelt, RN, patient & family education coordinator, Children's Healthcare of Atlanta, 1001 Johnson Ferry Road N.E., Atlanta, GA 30342. Telephone: (404) 929-8641. Fax: (404) 929-8690. E-mail: kathy.ordelt@choa.org. ■

Outpatient Surgery Unplanned Admission Data Collection Form

Patient Name _____
Procedure _____
Surgeon _____
Preop ASA Score _____
PACU Admit Score _____

Med Rec# _____
Date of Procedure _____
Anesthesiologist _____
Type of Anesthesia _____
Payer: _____

Patient attended preop class? __ Yes __ No __ Unknown

CLINICAL CAUSES OF POST-PROCEDURE ADMISSION (check all that apply)

RESPIRATORY
__ Obstructed airway/respiratory arrest
__ Reintubation
__ Decreased oxygen saturation
__ Respiratory depression
__ Prolonged intubation

CARDIOVASCULAR
__ Hypotension
__ Hypertension
__ Chest pain
__ Arrhythmia(s)

NEUROLOGIC
__ Deficit not present pre-op

MISCELLANEOUS CLINICAL CAUSES
__ Excessive drowsiness
__ Pain management
__ Excessive nausea/vomiting
__ Temperature < 94° or > 101°
__ Bleeding
__ Low urine output
__ Spinal anesthesia - slow to move
__ Extended observation needed
__ Unable to tolerate activity
__ Other: _____

NON-CLINICAL CAUSES OF POST-PROCEDURE ADMISSION (check all that apply)

__ Patient arrived late on admission
__ Discharge planning problem that was not identified prior to admission
__ No one available to pick up patient
__ Post-hospital caregiver not available to receive patient care instructions
__ Patient has knowledge deficit
__ Other: _____

SYSTEM-RELATED CAUSES OF POST-PROCEDURE ADMISSION (check all that apply)

__ Surgery start time delayed
__ Equipment unavailable
__ Short stay unit closing
__ Change of shift
__ Awaiting MD discharge order
__ Awaiting assessment by anesthesiologist
__ No call from anesthesiologist
__ Incomplete documentation
__ Manual CO2 expulsion not done
__ Case manager unavailable to handle discharge planning problem
__ Patient unaware of plans for same day discharge
__ Other: _____

Source: Patrice Spath, RHIT, Brown-Spath Associates, Forest Grove, OR.

(Continued from page 118)

of resource control. Physicians may unknowingly subject patients to a day-stay experience because of managed care pressures when a planned inpatient admission would have been more appropriate. Patients and families may need education regarding post-surgical symptomatology with the understanding that post-discharge supportive care must be arranged. The nursing units must be staffed adequately to ensure timely discharge of patients. Patients who are considered high-risk for post-surgical complications (preoperative ASA categories 3-4) might not be candidates for some outpatient procedures. Consideration might be given to decreasing reliance on general anesthesia in those procedures where straight local or nerve block anesthesia could be substituted satisfactorily. Studies such as this post-ambulatory surgery retention evaluation will aid the medical staff and the institution in identifying areas for both cost control and quality improvement. ■

Clarification

In the May 2000 issue of *Hospital Case Management*, consulting editor **Toni Cesta**, PhD, RN, FAAN, director of case management at Saint Vincents Hospital and Medical Center in New York City, stated that while employers are "looking for some kind of certification in case management, if you have an advanced degree, you usually don't need certification." Cesta, who is a commissioner for the Commission for Case Manager Certification in Rolling Meadows, IL, would like to stress that, although employers might accept an applicant with an advanced degree alone, it is still highly desirable to obtain case management certification. ■

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Editor: **Kim Coghill**, (404) 262-5537, (kim.coghill@ahcpub.com).
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcpub.com).
Managing Editor: **Russ Underwood**, (404) 262-5521, (russ.underwood@ahcpub.com).
Senior Production Editor: **Brent Winter**, (404) 262-5401.

Editorial Questions

For questions or comments, call **Kim Coghill** at (404) 262-5537.

CE objectives

After reading each issue of *Hospital Case Management*, the nurse will be able to do the following:

- identify particular clinical, administrative, or regulatory issues related to the profession of case management;
- describe how those issues affect patients, case managers, hospitals, or the health care industry in general;
- cite practical solutions to problems associated with the issue, based on independent recommendations from clinicians at individual institutions or other authorities. ■