AMERICAN HEALTH CONSULTANTS®

HOSPITAL CASE MANAGEMENT™

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

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IN THIS ISSUE

In This Issue **continued on next page**

Case managers put a new face on subacute care

Case managers to improve efficiency, cut costs

As the distinctions between acute and long-term care become blurred, subacute care likely will play a more integrated role in health care delivery, according to experts in the field.

Subacute care is growing rapidly as a result of improvements in emergency medical care and technology, decreased lengths of stay, population growth, and changes in Medicare rules, says **Dana Carr**, MS, BSN, RN, director of case management at Hebrew Hospital Home Inc. in Bronx, NY.

And while more patients are entering subacute facilities, the function of case management within those systems has become increasingly important to the overall continuum of care.

The case manager's role in subacute care is multifunctional, says Carr, who implemented a three-person case management program 18 months ago at Hebrew Hospital, a 480-bed nonprofit skilled nursing facility (SNF). At Hebrew Hospital, the case manager coordinates the flow of patients through the facility and, in collaboration with the interdisciplinary team, works to optimize patient outcomes at the lowest possible cost. The case manager also acts as a liaison with entities such as the referral sources, the patient and family, the managed care organization, and the community-based physician.

"If implemented at the right point on the continuum, case management can accomplish all of those goals as well as enhance patient satisfaction through its advocacy role," says Carr.

In order to survive challenges posed by the

In This Issue **continued from page 145**

COMING IN FUTURE ISSUES

- Results from *Hospital Case Management's* annual salary survey
- Special report on case manager certification requirements
- Special quarterly supplement: *Patient Education Quarterly*
- Profile of a hospital that has case managers in its ED
- *Critical Path Network* on reducing morning sickness among expectant mothers

Balanced Budget Act of 1997, SNFs are being forced to adopt creative and cost-effective ways of operating. Some strategies involve developing protocols that address education, quality, and teamwork, and evaluating the organization's goals, mission, philosophy, and vision. Also, properly managing resources, case mix, and associated costs is crucial to success under cost containment, Carr says.

Case management will become even more important to subacute facilities as the number of middle-aged consumers in need of care grows. Also, there is an attitude among many managed care companies that subacute care should replace continued hospital stays or, in some cases, any hospital stay at all.

The national market for subacute care is projected to expand rapidly. Regardless, budget constraints have forced facilities to tighten their belts and explore ways of saving money.

Case management necessary for success

Part of the goal on a subacute level is to ensure that services are not being duplicated. Eliminating duplication, in turn, promotes efficiency and cost effectiveness.

And while the definition of case management can vary from facility to facility, Carr says at Hebrew Hospital it is not simply a marketing function of "going and bringing patients into the nursing home." Rather, she says the case managers track patients across several levels of care, and the system is designed to manage patients' needs regardless of where care is being provided.

Subacute care can add seven to 25 days to a patient's confinement in a facility, and during that time, delivery of care must be well-coordinated, efficacious, efficient, and cost-effective. "The process ideally begins when the referral document is received by the SNF," says Carr.

Maura Lyons, RN, BSN, a case manager at Hebrew Hospital Home, says upon receiving a referral, she visits with the patient and family to determine if Hebrew Hospital can meet the patient's needs. "It's extremely important that you screen the patient so that you can customize or individualize a treatment plan," she says. "That's why it is important to have case managers in subacute care."

Lyons adds that much of her job involves education — of patients, family, and hospital staff. "People need to know what we do here. We have the whole continuum of care, and a patient is

Case Management Infrastructure

According to **Dana Carr**, MS, BSN, RN, director of case management at Hebrew Hospital Home Inc. in Bronx, NY, case managers in a subacute setting should have or have access to:

- ✔ Office space to increase accessibility of the case manager
- ✔ Desktop or laptop computer
- ✔ Access to equipment including fax machine, photocopier, telephone, pager, e-mail
- ✔ Access to continuing education both inside and outside the facility
- ✔ Subscriptions to relevant journals
- ✔ Business cards and relevant marketing materials that identify the organization's mission, vision, values, and goals

Role of the case manager in subacute care

- ✔ Interface with admitting, nursing, rehabilitative therapy, social work, pharmacy, finance, and quality assurance
- ✔ Identify patients and coordinate care
- ✔ Participate in the development and implementation of the care plan and the ongoing evaluation of specific skilled interventions
- ✔ Ensure that documentation is appropriate
- ✔ Attend daily rounds on subacute admissions
- ✔ Work with finance and quality assurance to effect appropriate resolutions
- ✔ Assist in the coordination of discharge planning by consulting with the patient and family, social worker, managed care organization and others
- ✔ Collaborate with the patient's primary care physician along with the physician at the skilled nursing facility (SNF) in order to provide a smoother transition
- ✔ Market the organization's programs and services
- ✔ Act as a liaison between the SNF and other facilities ■

much better off being here than in the hospital."

In most acute care settings, patients are being discharged quicker and sicker. "As we enter the 21st century and the baby boomers approach old age, the way in which we care for our elderly will influence many aspects of life for all age groups in our society," Carr says.

Case managers will need to be patient advocates, providing follow-up services to determine whether the patient is continuing to receive appropriate care.

Lyons works as an advocate, splitting her time evenly between clinical and marketing duties. "Whenever you are doing anything in nursing, I believe you are marketing, in that you are relating to the patient, the family, the staff, and you are representing your facility. You really must see yourself as a representative of the facility with a focus on patient care, quality of care, and doing what is right for the patient and family," she says.

Hebrew Hospital implemented case management in January 1999, and since then, the SNF has increased its ability to care for patients in an environment where their reimbursement will no longer pay for acute care.

The department has allowed Hebrew Hospital to market its facility as having professional case managers on board who can coordinate care and act as a liaison with the acute care facility.

"In many cases, when patients leave the hospital they think of going home," says Carr. "They don't think of going somewhere else for interim care before they go home. For us, it is really an opportunity to bring case management to that patient to initiate an education process, which says, 'You are not just going to a nursing home, and as a representative of the facility, it is my goal to get you through the system.' Families and patients appreciate that. And a lot of times that is why patients prefer us."

And if the patient gets sick again and requires acute care, the case manager follows up with the hospital and re-evaluates the level of care. This will include an on-site assessment and conference with the acute-care team. These activities facilitate the patient's return to subacute if that level of care continues to be required. "That's a big part of it," Carr says. "Before we had case managers, we had to rely on the social worker in the hospital to say the patient is ready to come back [to the SNF]. Now we are able to better plan for care based on an on-site skilled professional assessment made by our own staff."

The move to case management requires a team approach. Therefore, key organizational players must come together and take an active role in the development, implementation, and transition process, according to Carr.

It is critical to the success of a program that all players are clear about the role and importance of case management in the organizational structure.

Since some departments likely will feel threatened by an RN taking on the role of case manager

and its related activities, Carr says the role must be clearly defined so others, particularly members of the interdisciplinary team, can see the benefits.

"The role is a collaborative and consultative one, with a strong emphasis on clinical expertise and skilled assessment," she says.

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Part Two of a Two-Part Series

Chronic illness subject of successful program

Improved health, better care from partnership

Intermountain Health Care (IHC) of Salt Lake City has helped improve the health of many of its chronically ill patients through a program that places care managers in physicians' offices.

About four years ago, when IHC began researching ways to extend its reach and improve care for the chronically ill, it assigned two home health employees to physicians' offices and told them to help doctors manage the patients. IHC is a nonprofit charitable health care organization made up of 21 hospitals, an insurance company, clinics, and about 400 physicians' practices. IHC serves about 500,000 clients under its insurance plan.

The pilot program was so successful that IHC added more case managers, eventually reaching a total of 12. Their mission is to educate and coach, says **Jill Hoggard-Green**, RN, PhD, assistant vice president of clinical support services at IHC.

What do the case managers do?

"The first year we did this, we also had a mission of improving health by focusing on health promotion," she says. "While it was beneficial from a patient's perspective, we didn't find a lot of outcomes of either reduction of risk factors or reduction of costs, since health behavior changes take a lot of time. But we did find if we worked with individuals with chronic diseases, we saw huge changes in health behaviors, clinical outcomes, and costs."

In a pragmatic and functional manner, the case managers assume whatever tasks are necessary to improve the health of a patient.

Each of the 12 case managers was placed in a physician's clinic (except in one clinic where two case managers were assigned). The number of physicians at each clinic varied from between four and eight to between 12 and 48. "But we have found that once you get beyond 24, the care manager really doesn't get to know the doctors well enough to build a relationship," she says. "The best number seems to be 12 to 15, but some people say four physicians is best."

About 70% of the patients assigned to the case managers have a chronic illness, while 32% have two or more. The top two illnesses are diabetes and asthma. But a third condition — mental health issues — often enters into the equation. "If I look at a secondary diagnosis, there were more patients with depression and anxiety as a diagnosis than there were of diabetes," Hoggard-Green says. "Almost everyone had some sort of psychosocial issue that was making it more difficult to deal with the problem."

Although they hold classes and bring groups of people together, Hoggard-Green says the most effective interventions are the ones where the case manager spends time with the patient on the telephone or in person. "It is very specific," she says. "If you are working with an individual with diabetes, it is not [about just] sitting down for an hour and going over all the foods they can and cannot eat."

Rather, she says, it involves a visit to the house or a phone call placed by the case manager who asks, "How did you do last week? What is your goal this week?" Instead of simply teaching a concept, case managers show patients how to apply a concept to their daily lives.

The care managers do facilitate complex plans of care, as most are multiple specialists who use many services and disciplines.

In following up on efficiency of the program, Hoggard-Green says some of the care managers report there are times when the needs of one patient are so complex they consume an entire day. Other times, a care manager can spend the day making follow-up telephone calls.

During a one-year period, the eight care managers assigned to physician offices handled

approximately 4,000 patient visits. The average number of contacts per patient is 3.7. Hoggard-Green says the latter figure is misleading considering that in some cases the patient needs one intervention, while in others, particularly those involving patients with a chronic illness, seven to 10 visits are needed. "We let the patients tell us when they don't need to see us anymore," she says.

Case manager empowers patient

The program's organizers were pleased when interviews with patients and doctors netted positive results. Before they began meeting with the case manager, "Many patients said their health was going downhill, and they felt an inability to cope with an overwhelming situation," Hoggard-Green says.

Many patients described themselves as depressed, anxious, frightened, and frustrated with the lack of communication with their physician, and lacking in the knowledge and resources necessary to get their needs met.

Following intervention — and regardless of whether that intervention included one, two, three, or more meetings or communications with the case manager — patients talked about feeling "empowered" and experiencing "positive changes in their lives," Hoggard-Green says.

"We weren't setting up dependencies," she says. "[Case managers] were coaching people into believing and understanding that they could do it and giving them the tools and the resources over time to let them do it. It was one of those fundamental values of social work and nursing, 'helping people help themselves.'"

When asked to describe the care manager, patients and family members used words such as caring, supportive, accessible, advocate, champion of my cause, communicates with you, coordinates with the physician, educates, and arranges for services.

"Patients felt that they had more access to their doctors than ever before," she says.

Doctors said having case managers in their office helped improve quality of care and their relationship with their patients.

"They were really worried at first about what it was going to do to their relationship with the patient," Hoggard-Green says. "There was concern that it would diminish their role. But it didn't. Rather, the consumer attributed the intervention to the doctor, and they thought it was fabulous."

They said the case management program helped reduce the number of inappropriate trips to the emergency room, and they felt the patients' needs were being better addressed.

Doctors also reported improved productivity, "not that they were working 10 hours a day instead of 12 hours. But they felt more productive because they could spend appropriate time with each patient."

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Following the path to improved outcomes

Even the little guys can make use of protocols

If you work in an 80-bed hospital, you probably have many issues to worry about. Being able to deliver the highest quality of care with more limited resources than colleagues in big city hospitals is one of them. And if you wanted to start a new program designed to improve quality, you might not have the staff to do so.

But Valley View Hospital in Glenwood Springs, CO, has started a clinical pathway program that has saved the facility millions of dollars and hundreds of bed days.

Cathy LaBaw, RN, director of performance improvement, worked with clinical pathway coordinator **Linn Kight**, RN, to develop 22 different paths over the course of four years.

Making improvements to a stable system

"In 1996 when the effort began, our hospital was financially stable, had good outcomes, did well with regulators, and had high patient satisfaction," says LaBaw. "We had no compelling need to make a radical change. Instead, the initial decision to begin was the result of a grass-roots effort by nursing staff who recognized the value of pathways and managed to convince a particular physician to champion the effort to do a path for community-acquired pneumonia."

Kight notes that decreasing resource utilization, though, was always in the back of the minds

of those who participated in the program.

Several people who were interested attended a training session on clinical pathway development methodology. After the path was created, it was implemented by a multidisciplinary team of clinical caregivers. "The learning curve was steep and long," LaBaw recalls. "Not only because this was a new process, but because pneumonia was, and remains, a difficult condition to develop practice guidelines for."

That first pathway process helped the group work through some general difficulties. Now Kight researches new pathways to determine internal and external best practices. Using existing pathways, suggested data goals from various specialty societies, and other published work, she comes up with the basis for a new pathway.

For example, Kight says the Chicago-based American Hospital Association recommends that patients with chest pain get aspirin within 20 minutes. "Our target time is 10 minutes, and right now we are at about 12 minutes," she notes. The group is working to further improve that by continuing community education on the importance of taking aspirin if a heart attack is suspected, and working with the local ambulance service to administer the aspirin at the home or en route to the hospital.

"Depending on its focus, the pathway is then assigned to one of three existing collaborative care teams: surgery, medicine, or peripeds," LaBaw adds.

The teams meet for four hours every month, with fairly consistent membership. During the meetings, the teams work on new pathways, evaluate data from existing paths, and review older pathways to see if they need updating, says Kight.

One reason LaBaw says the effort has gone smoothly is that the clinical pathway steering committee included people from every area of the hospital. Physicians, other clinicians, and administrative staff all participated, she says. "Eventually the data began speaking for itself, and that has 'sold' many physicians."

The goal has always been to combine better outcomes while lowering average length of stay and charges. With the 22 pathways, there have been nearly 680 patient days saved, $1.4 million in charges eliminated, and more than $1 million in cost savings. Readmission rates have declined by 43%.

"Additionally, each pathway has two or three dedicated quality outcome indicators, each of which shows improvement or maintenance of satisfactory results," LaBaw says.

Perhaps the most telling evidence of how well the program works is that physicians use it, says LaBaw. "We don't require them to use the pathways, but they do it. The orders are written, the process was developed against the standard of care, and it has eased their administrative burdens. They love it."

LaBaw adds that having the pathways in place has helped the hospital in its managed care contract negotiations. "This isn't a very high managed care area, but we use [the pathway program] when we negotiate, and it does provide leverage."

Data-driven quality improvement

Another measurement of success has been the hospital's ability to use the data gathered because of the pathways to make further improvements. LaBaw notes that physicians wanted to make sure that patients received preoperative antibiotics within 60 minutes of having the first incision during their surgery.

By looking at data collected from other pathways, she knew they weren't in that window. "We revised pathways based on that knowledge, and we were able to bring it from an average of 67 minutes prior to the changes to 30 minutes after them," LaBaw says. "Having data often provides us with ideas for improvements. And we analyze the data regularly."

The data are reviewed in the collaborative care team meetings, and also with process improvement teams and among physician groups, says LaBaw. The board also sees data every six months.

Costs can be cut only so much, Kight admits. "Everyone has to work smarter and more efficiently, but this takes a multidisciplinary plan of care and tools that allow everyone to care for patients in a like manner."

The next step, Kight adds, is expanding the pathway process throughout the continuum of care. "We are trying to bring it into home health, nursing homes, and even one physician's office so that wherever patients go we can help them reach a better level of wellness."

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CRITICAL PATH NETWORK™

Pneumonia pathway reduces LOS and saves money

By **Brenda S. Holland**, MSN, RN
CareWays Coordinator
Department of Care Management
Alamance Regional Medical Center
Burlington, NC

In today's cost-conscious environment, the cost of health care is spiraling out of control. At the same time, society is demanding better health care, scientists are searching for more cures, and the government is trying to control costs. To compete in this health care environment, hospitals and health care professionals must develop a centrally organized process of care based on research and analysis to help set priorities for this new and ever-changing health care environment.

To adapt, Alamance Regional Medical Center in Burlington, NC, began developing the Pneumonia CareWay Sept. 27, 1995. It was implemented July 6, 1996. The Pneumonia CareWay focus group that developed the multidisciplinary process included:

- a pulmonologist;
- family medicine;
- medical-surgical nurse;
- emergency room nurse;
- finance department;
- infection control nurse;
- pharmacy;
- cardiopulmonary department;
- CareWay's coordinator.

Literature indicates that pneumonia was the sixth leading cause of death in the United States and the No. 1 cause of death from infectious diseases in 1993. Among patients with community acquired pneumonia requiring hospitalization, mortality rates approached 25% during this period. Potential adverse outcomes for this illness include increased length of stay and death. These two outcomes alone would indicate an increase in hospital charges and resource utilization.

Because pneumonia is not a reportable disease, exact information about its incidence is not available, but it is estimated that up to 4 million cases occur annually. Both the American and British Thoracic societies published guidelines in 1993 that suggest that patients who receive adequate sputum and blood cultures before antibiotic therapy and for whom the appropriate antibiotic is initiated within four hours of admission have significantly better outcomes.

The Pneumonia CareWay is the result of a 10-month-long effort to examine the initial care provided to all patients admitted with the diagnosis of pneumonia, or DRG 89. Patients are placed on the CareWay while in the emergency room department. This factor alone decreased the time frame for obtaining sputum and blood cultures. Since the blood and sputum cultures are collected earlier, the average time from admission to the emergency room and administration of antibiotics is four hours and six minutes. The mean average length of stay for this patient population decreased from nine days to 4.5 days. Quality care with cost-effective measures benefited both the hospital and patient on the Pneumonia CareWay.

In 1997, the multidisciplinary team reviewed all data the initial Pneumonia CareWay had provided. It reviewed current practices and reimbursement issues and decided a five-day stay would provide quality care while reducing costs for patients and payers. The updated Pneumonia CareWay was implemented September 1997.

CareWay revisions must be a continuous process if a hospital is to survive. The Pneumonia CareWay

(Continued on page 154)

ARMC
Pneumonia CareWay CWPNEUGENERAL 5/00
Expected LOS: 5 Days DRG 89

CareWays are to be used as suggested guidelines only and do not constitute standards of care.
INSTRUCTIONS FOR USE: Initial CareWay Outcome when met or completed.
Draw a solid line through areas that are not applicable and initial.
Place a "V" by an Outcome if unable to meet.
Document reason for variance on the Variance Form on the back.

Addressograph

Category	Day 1 Date :	Day 2 Date:	Day 3 Date:
Patient Outcomes	**Antibiotics started within 4 hrs of admission** **Oximetry O2 Sat. 95%** **Patient/caregiver understand diagnosis and treatment plan**	**Coughing productively** **Decreased dyspnea with activity**	**Change to PO antibiotics** **Verbalizes signs/symptoms of pulmonary infection** **Discharge plan identified**
Medications	IV as ordered 1ST dose antibiotics given IV after obtaining sputum or within 4 hrs of admission	IV as ordered IV antibiotics	IV or NS Lock PO Antibiotics
Activity/ Safety	HOB up 30 degrees BRP as tolerated	OOB TID as tolerated	Ambulating without dyspnea
Diagnostics / Procedures	Hemogram, Met C, Blood cultures x 2, Sputum for C&S, AFB culture, Oximetry, EKG, CXR PA/Lat	Hemogram Met B Oximetry	Hemogram Met B Oximetry
Nutrition / Dietary	Diet as ordered Encourage fluids	Diet as ordered	Diet as ordered
Education	Review patient CareWay Education on diagnosis and treatment plan Educate on smoking cessation if appropriate	Review patient CareWay Educate on how to turn, cough, and deep breath How to recognize and prevent respiratory infection Educate on diagnosis and treatment plan	Review patient CareWay Review how to recognize and prevent respiratory infections Encourage flu/pneumoccal vaccine Review turning, coughing, and deep breathing exercises
Nursing Assessment	Initiate Pneumonia CareWay Admission assessment information Vital signs every 4 hours x 6 I&O Weight	Vital signs every shift I&O Weight	Vital signs every shift I&O Weight
Consults / Therapy	Pulmonary Specialist	Chaplain Dietitian	
Discharge Planning	Social Worker/Care Manager for discharge needs	Discharge needs identified	Verbalizes diagnosis, treatment, and discharge plan
Patient Problems	_____	_____	_____

Source: Alamance Regional Medical Center, Burlington, NC.

ARMC
Pneumonia CareWay CWPNEUGENERAL 5/00
Expected LOS: 5 Days DRG 89

CareWays are to be used as suggested guidelines only and do not constitute standards of care.
INSTRUCTIONS FOR USE: Initial CareWay Outcome when met or completed.
Draw a solid line through areas that are not applicable and initial.
Place a "V" by an Outcome if unable to meet.
Document reason for variance on the Variance Form on the back

Addressograph

Category	Day 4 Date:	Day 5 Date:	Date:
Patient Outcomes	**Pulse oximetry >/= 94% on room air** **Afebrile times 24 hours and on PO antibiotics** **Verbalizes diagnosis, treatment, and discharge plan**	**Discharged on PO antibiotics** **Verbalizes discharge plan** **Follow-up appointments arranged**	
Medications	D/C IV or NS Lock PO Antibiotics	PO Antibiotics	
Activity/ Safety	Activity as tolerated	Activity as tolerated	
Diagnostics / Procedures	Turning, coughing, and deep breathing		
Nutrition / Dietary	Discharge diet	Discharge diet Instruct on discharge diet	
Education	Review patient CareWay Educate on discharge medications Review diagnosis, treatment, and discharge plan	Review patient CareWay Review discharge medications Review diagnosis, treatment, and discharge plan	
Nursing Assessment	Vital signs every shift	Vital signs every shift	
Consults / Therapy	Lifestyles center for smoking cessation if needed		
Discharge Planning	Discharge plan reviewed with patient/caregiver Able to verbalize when to/how to re-access healthcare system if needed	All follow-up needs completed	
Patient Problems	_____ _____	_____ _____	_____ _____

Source: Alamance Regional Medical Center, Burlington, NC.

ALAMANCE Regional Medical Center

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BURLINGTON, NC 27216

PHYSICIAN'S ORDERS

ANOTHER BRAND OF DRUG IDENTICAL IN FORM
AND CONTENT MAY BE DISPENSED UNLESS CHECKED ____

DATE & TIME	____ INPATIENT ADMISSION ____ OUTPATIENT OBSERVATION
	PNEUMONIA CAREWAY
	Admit to Dr.
	Admit to _____ICU _____Telemetry Unit _____Floor _____Suspected TB
	_____Isolation
	Vital Signs q 4 hrs. x 24 hrs., then q 6 hrs.
	Diet_____as tolerated. Encourage Fluids.
	Activity: _____Advance per CareWay or _____
	Intake and Output _____Daily Weights on admission and x 3 days
	Allergies:
	Labs: _____Blood Cultures x 2, 15 minutes apart 2 different sites _____Sputum C&S
	_____AFB Culture, Smear _____MET C _____Hemogram
	_____Oximetry. If Saturation < 94% do ABG. _____EKG _____CXR PA and Lat
	In AM:
	_____Oximetry. Adjust O2 to 95% _____ABG. if O2 < 94% on Room Air
	_____Hemogram, _____Met B
	Medications:
	After Sputum and Blood Cultures obtained or within 4 hrs. of admission,
	start antibiotics _____IV
	_____PO
	Pharmacy to notify MD when criteria to change to PO antibiotics met
	Suggested Criteria to Change to PO Antibiotics
	Temperature < 100 x 12 hrs., RR < 24, decreased WBC
	O2 @ _____Liter/Minute
	Consults:

(Continued from page 151)

is no exception. This multidisciplinary team met again Feb. 2, 1999, to re-examine data analysis, literature, and reimbursement information. Literature revealed that these four quality indicators were effective in gaining positive outcomes:

- antibiotics within four hours of admission;
- blood culture within 24 hours of arrival;
- blood culture before antibiotic was given;
- oxygenation assessed within 24 hours of arrival.

Two indicators are being added to the list of positive outcomes and quality care for the Pneumonia CareWay patients:

- inpatients with pneumonia screened for or given influenza vaccination;
- inpatients with pneumonia screened for or given pneumococcal vaccination.

Pneumonia and influenza cause substantial morbidity and mortality for our older patients. These last two quality indicators present opportunities for improvement for our Medicare patient population, which constitutes approximately 46% of our payer mix. Future improvements in quality outcome indicators and cost effectiveness likely will stem from continued review of research-based literature and analysis of the Pneumonia CareWay variance information. ■

Discharge Planning Advisor®

— the update for improving continuity of care

- Accelerated discharge
- Staff cooperation
- Placement strategies
- Reimbursement
- Legal issues
- Case management

Do patients suffer if social work role is diluted?

LOS impact may be more than hospitals realize

Leaders in discharge planning are concerned that a cost-cutting measure that began in the early '90s may be compromising patient care at some of the nation's hospitals.

One of the effects of the health care re-engineering fever that began spreading across the country in the past decade, says **Jackie Birmingham**, RN, MS, CMAC, has been the downsizing — and in some cases disbanding — of social work departments. Birmingham is vice president of network integration for Integrated Health Networks in Newton, MA. "Some hospitals do not have social workers, in discharge planning or in social service. Nurses are taking on all the roles, and if a family is in crisis or needs grief counseling or needs to apply for some kind of social service outside the hospital, it is just not being done. I fear that in order to be cost-conscious and do discharge planning, hospitals are getting rid of social workers."

The Medicaid population is particularly at risk in such a scenario, Birmingham suggests, as are patients in managed Medicare plans. "A lot of payers are pulling out of managed Medicare, where there are case managers that work with patients. Will that change what discharge planners need to do for Medicare patients?"

If the social work function is eliminated, she says, discharge planners may need to spend more time with Medicaid and Medicare patients. With shorter hospital lengths of stay, patients often have greater social service needs, as well as greater medical needs, Birmingham points out.

The former can include helping families adapt to major trauma, assisting stroke patients who need to change their lifestyle, and grief counseling, among other services, she says. "Some hospitals believe any patient in the intensive care unit needs to have family social support. Pastoral counselors are picking up some of the slack, and they are trained in that, but some families need more in-depth work than a pastoral counselor can provide."

"There is no doubt that there is an overall trend toward downsizing the social work [function]," says **Sandra Lowery**, RN, BSN, CRRN, CCM, president of the Case Management Society of America in Little Rock, AR. "It is in different phases at different hospitals. Some have completely eliminated social workers and had nurses [take over patient management]. I think that's a very small percentage.

"Most commonly," adds Lowery, who also is president of the consulting firm CCMI Associates, based in Francestown, NH, "the nurses who are transitioned into these roles are not getting the training they need to assume these responsibilities. It's a different dynamic. Just educationally, some registered nurses have two years of preparation for their role, while almost all social workers in hospitals have master's degrees or more."

Most hospitals have brought social services under the case management department, with the social workers often reporting to the director of case management, she notes. Lowery cites four social work models she has seen:

1. Social work is still autonomous and hasn't changed from its traditional role.

The norm until three or four years ago, this scenario is "very rare" today, Lowery notes. In fact, a call to a facility she described as having one of the strongest social work directors and departments revealed that the director no longer worked there, and the position had been downgraded to "manager."

2. Social workers share case management roles and responsibilities with nurses.

In this model, she says, parallel positions are drawn along the lines of either geography or

population. "For example, if I had a population that needed long-term care placement or facility placement, those patients might be designated for social workers. Those who are going home and might need assistance for home care are under the auspices of a nurse case manager."

3. The social worker is a resource to the case manager and others, but is not really carrying a caseload.

"This is another common one," Lowery says. "The social worker is a resource for working with difficult patients or family dynamics or with families who have more intensive psychosocial needs." In this model, the social worker does crisis intervention and counseling, she adds, "really following the traditional role of the social worker. The discharge planning for care needs has been transitioned to the case manager, and the social worker is providing supporting and consulting services. It's a very much smaller role — that's where we're seeing the downsizing."

4. Social worker/nurse teams provide case management.

"I'm seeing an increase is this kind of 'co-management,'" she says, "and that's where I'm seeing the only growth [in the social work role]. It could be an outcome of hospitals' realizing their mistake [in downplaying the social work function] and bringing it back, but not in the traditional role." In this model, Lowery adds, these teams may manage behavioral health patients, for example, or they may work in the emergency department. Certainly geriatrics will be included, she notes.

'Like an amoeba'

The recent downsizing of the social work function in hospitals "is one of those phenomena that has been like an amoeba," says **Kim Fuller**, ACSW, director of social work at Research Hospital in Kansas City, MO. "It takes different shapes in different places. Sometimes it is more prevalent, and at other times, the status quo of social work staffing is maintained."

While social workers historically have done most of the discharge planning in hospitals, that began to change in the mid to late '80s, with the advent of diagnosis-related groups (DRGs) and health maintenance organizations, adds Fuller, who is president of the Missouri-Kansas Chapter of the Society for Social Work Leadership in Health Care in Chicago.

"The model of having tighter clinical management of the patient came to the forefront. Is all the testing getting done? Is there duplication? A new dimension of patient management began to evolve and nursing began to be identified as the discipline that was able to track and manage some of those practice patterns," she explains.

Although Fuller says she agrees with the idea that nursing brings value to this level of patient management, her concern is that many hospitals are making decisions to reduce or eliminate services without a thorough analysis of the impact of those changes.

"Nursing and social work have tremendous contributions to make to patient care," she adds, "and it is possible to have a model that utilizes the strengths of both disciplines that is still cost efficient."

Kathleen Eaugh, RN, MN, an Atlanta-based manager in the health care consulting practice of Pricewaterhousecoopers, says her firm is sometimes called in to remedy the situation when hospitals fail to understand the implications of the changes they make in the care continuum.

Most hospitals with large social work departments have reduced them, and/or integrated them into the case management department, she says. "It is my opinion that through that evolution, some of the [social work function] has become diluted."

Although the concept of having someone at a higher level oversee the patient's care is sound, the merging of jobs and multitasking that often take place under the case management heading are not always the best way to provide care, she notes. "It's difficult to gain efficiency when you have someone doing all those functions.

"Maybe the discharge planning activity has now become the responsibility of the nurse at the bedside," she continues. "Given that the first priority at the bedside is to meet the physical needs of the patient and that the nurse may not have the knowledge base to access the necessary services, [discharge planning] is not done as effectively. The person is staying in the hospital longer than need be."

In some cases, she says, her firm's recommendation has been that, instead of everyone being a generalist, there should be a group specializing in discharge planning. As for whether that means recommending the social work role be restored, she adds, the answer is "yes and no. Some of our recommendations have been for the hospital to do a better job of delineating functions, to say, 'Instead of having one case manager do 15 things, look at consolidating some of those functions.'

"Social work is a key component of taking care of patients, and the need for that hasn't gone away," Eaugh says. "That is specialized knowledge. How we determine to package it has changed over time."

At Emerson Hospital in Concord, MA, the "packaging" of the social work function has changed a couple of times over the past five years. At that time, the hospital combined the formerly separate departments of social work, discharge planning, and utilization review into one social work/discharge planning department, says **Mary Lou Cunningham**, RN, MS, manager for the department of social work and care coordination for both the hospital and the Emerson Physician-Hospital Organization.

When she was hired three years ago, the mission was to create a case management department that also included the other functions. "We're working on figuring out how it will look," Cunningham says.

"Case management is a nursing role, but we use our social work colleagues as consultants on difficult cases, such as a hospice case, or a difficult nursing home placement," she notes. "They are called in as needed."

The social work staff were downsized in the first reorganization, but there have been no cuts since her arrival, adds Cunningham, who now oversees 6.75 nurse case manager full-time equivalents (FTEs) and 2.75 social work FTEs. Social work is handled on the weekends with "beeper coverage," she says, and there may be a reduction in the hours the social worker is available by beeper.

Elderly patients often lack support of family

With today's mobile society, where family support is often not available for elderly patients, the social work role is crucial, Cunningham says. "If there is no social worker available to deal with and sort out those situations, somebody has to do it. If it falls on nursing, then it takes nurses away from their responsibilities in delivering medical care.

"Nobody will be kicked out onto the parking lot because the family can't figure out what to do," she points out, "so there could be a significant impact on a hospital's average length of stay. These are not issues that are easily sorted out."

Despite the trend toward reducing or eliminating social work departments, Lowery points out, "there is a glimmer of hope" indicating the function will remain strong and viable, perhaps in a new form.

"I am seeing a resurgence in some hospitals that have recognized the value of social work, who have seen the light," she says. "They are starting to understand how to strike that balance, that they do need to have social workers." Some organizations, Lowery adds, are realizing that social workers have a real role to play in "pre-hospitalization" — assisting those who are high risk out in the community prior to their needing hospitalization.

"Other roles social workers are playing within the case management department are the development and management of support groups," she notes, "or working within community resource development. Social workers are also working as trainers for case managers who need to pick up their knowledge base in the area of community resources." ■

Take off the blinders, social workers advised

Health care administrators often make decisions — such as downplaying, or even eliminating the role of social workers — at a level that is out of the caregiver's sphere of influence. Your job may be eliminated, and there may be nothing you can do about it, says **Kim Fuller**, ACSW, director of social work at Research Hospital in Kansas City, MO.

On the other hand, suggests Fuller, who is president of the Missouri-Kansas Chapter of the Chicago-based Society for Social Work Leadership in Health Care, there are ways in which social workers can position themselves in as positive a light as possible, in case such drastic measures are avoidable.

"Social workers have long had limitations in doing some of the research and publication that are more common [in the nursing field] and in coming to the table and saying, 'These are the things we add to the bottom line,'" she says.

Because social work is more of a "soft science" in many ways, Fuller adds, it is difficult to quantify the interaction between social worker and patient. "The first time a person enters a nursing home, for example, a social worker — who is often master's prepared in a curriculum that really focuses on human behavior — comes to that interaction with a rich repertoire of skills.

"Working from the clinical side, in this case

'clinical' meaning psychosocial, the social worker can move to a decision that is better for the patient and the family," she says. "That is as opposed to the medical model, which tends to be much more outcome-focused, as in, 'We need to get this bed opened up.'"

Both approaches are necessary, Fuller says, but hospitals have been less likely to see social work as having measurable, positive effects on the bottom line. To remedy this, she advises, social workers need to educate themselves about the financial side of their organization.

"Don't just have the blinders on, and say, 'I'm here to work with the patient, and that's the only thing I care about,'" Fuller says. "Find ways to quantify and measure the contribution you're making, even in some fairly simplistic ways. Do outcome studies and provide the data to administrators. Show that because of early identification of the patient's needs, you were able to facilitate nursing home placement and reduce the length of stay. These are things that don't necessarily require you to be a statistician."

Although social workers traditionally have been reluctant to think in those terms, she says, they should become more willing to articulate their contributions. Committee memberships, Fuller adds, are another way to demonstrate the breadth of one's skills.

"Gaining more credibility in a general sense," she says, "might get you factored into decisions that are being made." ■

JCAHO will use HCFA restraint rule

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has decided to use the "one-hour standard" mandated by the Health Care Financing Administration (HCFA) for restraint and seclusion of patients having psychiatric or other behavioral disorders, clarifying a confusing discrepancy between the two organizations.

HCFA's interim final rule on patients' rights requires that any individual placed in restraint or seclusion be seen face to face by a physician or other licensed independent practitioner within an hour of that action.

In order to maintain its federal deemed status relationship, JCAHO announced in late August that it would use the one-hour standard in surveys starting Sept. 1. HCFA and JCAHO are in discussions about HCFA's patients rights conditions of participation and JCAHO's standards.

Mark Covall, executive director of the National Association of Psychiatric Health Systems, says it is possible, but highly improbable, that the dialogue could cause HCFA to change its standard. The American Hospital Association has challenged the one-hour rule in a suit filed last summer. ■

A day less LOS saves little, study says

The belief that reducing length of stay by one day will significantly reduce overall cost "is incorrect" because "not all hospital days are economically equivalent," according to a study in the August 2000 issue of the *Journal of the American College of Surgeons*.

The study found that the last full day of hospitalization involves only incremental resource costs that total about $400 to $450. By eliminating the last day of hospitalization, a hospital would save only a small percentage of the total cost. According to the study, "the early phase of care involves expensive diagnosis and intervention, while the final days are essentially recuperative."

The study is on-line at http://www.facs.org/about_college/acsdept/jacs/lead_articles/aug00lead.html. ■

Web site lists 9 'triggers'

An article posted on the Healthcare Intelligence Network Web site (www.hin.com) cites nine instances that might trigger violence among hospital patients or workers.

Health care organizations need to be aware of potential problems wrote Fredrick Roll, executive vice president of Healthcare Security Services in Denver.

Roll added that most health care providers are "flying by the seat of their pants" regarding prevention of violence in the workplace. The article points to an article in a recent *Journal of Healthcare Safety, Compliance & Infection Control* showing health care workers at high risk of being attacked on the job. ■

Discharge planners can go on-line to place patients

eDischarge eliminates phone calls, faxes

Discharge planners employed by Winchester (MA) Hospital have spent the last several months getting a first-hand look at how technology and the Internet can simplify some of their duties.

In the spring, they began piloting eDischarge, an Internet-based program that links the hospital staff to post-acute providers and payers, centralizing information that a case manager needs to discharge patients efficiently to the most appropriate facilities. The program is clinically based and was designed by health care providers, says **Jackie Birmingham**, RN, MS, CMAC, vice president of clinical design at Newton, MA-based Integrated Healthcare Network, the company that developed eDischarge.

Before discharge planners at Winchester began using eDischarge, they spent quite a bit of time each day dealing with reviewers or case managers from post-acute facilities, says **Ruth Pilote**, RN, MSM, a care manager at Winchester. Although that's considered just part of the job, it is time-consuming, particularly when four or five reviewers visit the unit within a few hours.

And when discharge planners weren't dealing one on one with reviewers, they were making calls or faxing information to post-acute facilities just to find a facility with a bed for a patient.

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Editorial Questions

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Under the new system, however, discharge planners simply enter in the patient's condition and post-acute care needs, and send an e-mail. A post-acute care facility that is enrolled in eDischarge and can accommodate the patient's needs is identified, and the process is essentially complete within about 45 minutes.

"It definitely cuts down on the number of phone calls, and it increases efficiency," says Pilote. "And in this fast-paced world, it's like a trigger. You know who you referred and you know where you referred them."

The system works this way:

• Post-acute providers that take referrals from a hospital, including skilled nursing homes, home health services, and rehabilitation facilities, complete an initial profile outlining the services they offer. Each day, the provider updates the bed or service availability.

• Case managers or discharge planners input the patient's continuing care needs and the date the patient will be ready for discharge. The specific patient is not identified.

• The system matches the availability of facilities or services with the needs of the patient.

• The discharge planner sends a notice via e-mail to the matched provider, by way of a secure Internet server, that a bed or service is being sought.

• The provider's intake coordinator reviews the patient care needs on the Web and responds to the hospital discharge planner.

• The patient and / or family is consulted in the final selection of the post-acute provider.

• To protect patient confidentiality, identifying information on the patient is sent to the provider only after the final match is made.

Many patients go to two or three levels of post-acute care before finding the level that fits their needs, often because they don't go to the right place the first time. Birmingham points out.

eDischarge will make a difference she says, "because the discharge planner will have a work flow tool that automatically matches the patient to the provider based on needs and availability. Discharge planners also will have more time to work with the complex patient to develop a more precise discharge plan."

Response has been favorable, Birmingham adds. "Discharge planners no longer have to rely on phone calls and faxes to get the job done. I call it the 'virtual discharge planning tool.'"

And for the families, eDischarge offers "patients and distant families access to what we're doing. We can e-mail the Web sites of nursing facilities to the families, where they can see a review of the nursing homes. They will have a unique code or password that will give them access to designated information they need to make a decision." ■

CE objectives

To earn continuing education (CE) credit for subscribing to *Hospital Case Management*, CE participants should be able to meet the following objectives after reading each issue:

• 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. ■

PATIENT SAFETY ALERT™

A quarterly supplement on best practices in safe patient care

Debate continues: Is pharmacist shortage creating risks?

More pharmacy schools opening, but that's not a short-term fix

Some industry experts fear the pharmacist shortage eventually will threaten patient safety as the demand for prescriptions increases from 3 billion to 4 billion by 2004. And while there is a growing need for pharmacists, the number of students entering pharmacy schools essentially remains the same year after year.

Carmen Catizone, executive director of the Park Ridge, IL-based National Association of Boards of Pharmacy, says the nature of the job creates a potential for danger. "Any time you dispense a prescription as a pharmacist and you make an error, patient safety is at risk. The volume [of prescriptions] certainly adds to the risk."

To reduce the chances of compromising safety, Catizone says there is a need for more pharmacists and better-trained technicians. But that isn't likely to happen within the next few years.

Pat Minard, PharmD, pharmacy manager at Shawnee Mission (KS) Medical Center, says there's no doubt that the shortage creates a risk for patients, particularly in the retail setting.

Minard says there are cases where retail pharmacists are under a lot of pressure to meet a bottom line. "Sometimes they end up working to the point where they are ignoring information screens where there could have been an interaction or they are asking technicians to do things that the pharmacist should be doing," he says.

Retail pharmacists also face a time crunch, Minard says. "Patients are more tolerant in a hospital," he says. "If it takes 30 minutes to fill a prescription, usually the patient doesn't know because he's upstairs in a bed. The nurse might get a little irritated. But standing around waiting in a drug store for 30 minutes is completely different."

He fills about 150 prescriptions during an eight-hour shift.

Lisa Abrams, MD, an internist at Lake Forest Hospital in Deerfield, IL, began working as a pharmacist in the early 1980s. Back then she would easily fill 600 prescriptions a day.

"This problem is not new," she says. "There's been a shortage for years even when I was starting out. I don't think patient safety is at risk because, by nature, pharma-cists have compulsive and obsessive personalities. "I would check and re-check a prescription, and I think other pharmacists do the same thing."

Patients suffer when pharmacists too busy

When pharmacists are under pressure to "lick, stick, count, and pour," the patient is the one who suffers, Minard says. "We are trained in pharmacy college to spend a lot of time counseling patients," he says. "You don't have time to do that in the retail setting."

Taking an extra few minutes to talk to a patient can dramatically reduce the likelihood of an error, most pharmacists agree. And indeed, a growing number of retail pharmacies are focusing more on patient care, says **Dan Kidder**, spokesman for Alexandria, VA-based National Association of Chain Drug Stores. "Chain stores are getting away from having pharmacists [getting stuck] behind the counter."

Kidder says no one doubts pharmacists need to

As patient safety issues gain importance, American Health Consultants has created this supplement as a service to our readers, to provide up-to-date information on patient safety issues and trends, together with expert advice on how to meet the coming imperative for better quality and safety in patient care. Special thanks to Safety-Centered Solutions Inc. for help in preparing this issue.

spend more time with patients. "Approximately 50% of prescriptions are taken improperly by the patient. The time spent with the patient is crucial."

But even **Richard Penna**, executive vice president of Alexandria, VA-based American Association of Colleges of Pharmacy, concedes that a pharmacist with the best intentions can inadvertently put a patient at risk. "I have no information to say the lack of pharmacists puts lives in danger. But you could make a case, similar with a physician in his residency who spends 36 hours on call. The last five or six hours are crucial time when errors occur.

"The same thing would hold true of pharmacy situations," he says. "They may not have time to double-check the order. One issue that does need to be dealt with is the amount of time pharmacists are spending with insurance companies," he says.

The solution to the pharmacist shortage seems obvious — recruit more pharmacy students. But that's easier said than done.

"In pharmacy, just like medicine, dentistry, and nursing, fewer and fewer people are entering the fields, and I don't know why," says Penna.

Some experts say careers in the medical field are taking a backseat to technology-based careers. "That has been mentioned by a variety of people and it sounds logical, but I don't know if it is the real reason." Pharmacy may not be as popular as technology because the hours are not regular and the salaries are not as high as in some computer-related positions.

New technology, however, can help support pharmacists in the delivery of better and safer care. One example is Excalibur Patient Safety Net, a software package and information system from Safety-Centered Solutions Inc. (SCS) in Tampa, FL. Excalibur includes reporting, analysis, and trending capabilities, as well as medical error and adverse drug reaction taxonomies to assure reliable data. Pharmacists using Excalibur have been able to significantly reduce the incidence of errors," says **David Spencer**, founder and CEO of SCS.

Pharmacy schools are doing their best to keep up with the demand. The 82 pharmacy schools across the country graduated 8,000 students in spring 2000.

New pharmacy schools are opening every year, but most graduate less than 100 students at a time. Meanwhile, there are 7,000 openings in drugstore chain pharmacies alone, and 94,000 pharmacists are employed nationwide. That doesn't count hospitals, community pharmacies, HMOs, and drug companies.

"Pharmacists are in demand by a lot of companies because of their knowledge of drugs," Penna says. "And that's all a part of it."

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Safety-Centered Solutions, hospital win software award

Safety-Centered Solutions Inc. (SCS) and one of its clients, University Community Hospital (UCH) of Tampa, FL, recently won the Healthcare Innovations in Technology Systems (HITS) "Partnership in Technology" Award for a system to improve patient safety by identifying, quantifying, and measuring the cost of adverse events.

The HITS Awards were established in 1992 by Henry Ford Health System, a leading managed care provider in the United States, and honor both inpatient and outpatient facilities in two categories for each classification based on size — small or large.

SCS and UCH were chosen in the large facility category based on their development and use of Excalibur Patient Safety Net, a proprietary software and information system that recognizes systemic causes of medical errors and subsequently reduces their frequency and associated costs.

"We are delighted that our collaboration with University Community Hospital was recognized by our industry at the national level," says **David Spencer**, founder and CEO of SCS. "Once again it proves that putting good tools into the hands of good people offers endless possibilities for permanent improvement in quality."

For further information on Safety-Centered Solutions Inc., contact: 7650 W. Courtney Campbell Causeway, Suite 400, Tampa, FL 33607. Telephone: (813) 626-0299 or toll-free (877) 739-6751. Web site: www.scCARE.com. ■

University study identifies problems with IOM report

The Institute of Medicine's (IOM) report on medical errors is faulty because it does not include a control group and all the patients studied on average were very sick, according to researchers at Indiana University School of Medicine in Indianapolis

"If you take their figures literally, you have to assume that patients never die if they do not suffer an adverse event," says **Clement J. McDonald**, MD, director of the Regenstrief Institute and Distinguished Professor of Medicine at Indiana University School of Medicine.

McDonald is referring to the study released by the IOM in November 1999 that stated "preventable adverse events are a leading cause of death" and "at least 44,000 and perhaps as many as 98,000 Americans die in hospitals each year as a result of medical errors."

Indiana University's report "Deaths Due to Medical Errors Are Exaggerated in Institute of Medicine Report"[1] was published July 5 in *The Journal of the American Medical Association* (*JAMA*). Lucian L. Leape, MD, adjunct professor of health policy in the Harvard School of Public Health in Boston, published a rebuttal piece, which ran in the same issue.[2]

McDonald and his colleagues at Indiana University, Michael Weiner, MD, MPH, assistant professor of medicine, and Siu L. Hui, PhD, professor of medicine, said that it is wrong for the IOM to assert that all deaths in the study group were caused by adverse events without reporting any kind of comparison or control group.[1]

Leape's colleague, **Thomas Nolan**, PhD, a statistician at the Institute for Health Care Improvement in Boston, says there was no control group because the IOM study is an analysis of other literature.

The IOM report is based on a Colorado and Utah study that implies that at least 44,000 Americans die each year as a result of medical errors, and on a New York study that suggests the number may be as high as 98,000.

In its high-severity group of 1,278 patients for whom an adverse event was identified, the IOM's study reported that 173 patients (13.6%) died, at least in part because of an adverse event.[2]

"Indeed, an assertion that adverse events caused death in 13.6% of the patients who experienced adverse events is tantamount to the assertion that there would be no deaths in a group with similar baseline risks who avoided all adverse events. Clinical experience tells us that is not true," McDonald wrote in *JAMA*.

Nolan says Leape's study eliminated people who were at high risk of death. "The analysis that Dr. McDonald did was not appropriate because Dr. McDonald did not take that into account. The whole issue comes down to whether they excluded the very sick — they did," he says.

Leape wrote that the group screened included people who were not very sick. Patients who had major surgery, acute myocardial infarction, pneumonia, or stroke or were terminally ill, extremely ill, or with a do-not-resuscitate order were eliminated.[2]

According to Leape, three reasons suggest that the IOM report did not exaggerate the extent of medical injury and death. First, despite the limits of record reviews, it is unlikely the reviewers found adverse events that did not exist. Second, neither of the large studies examined the extent of injuries that occur outside of the hospital. Finally, when prospective detailed studies are performed, almost invariably, error and injury rates are much higher than indicated by the large record-review studies.

Louis H. Diamond, MB, ChB, FACP, vice president and medical director of MEDSTAT Group Inc. in Washington, DC, and member of the board of directors of the Chicago-based National Patient Safety Foundation, says, "Although this has raised some methodological questions, it doesn't detract from the fundamental fact that errors are occurring at a rate higher than they should, and patients are harmed by these errors."

Nolan agrees, saying there's no question that people are dying from medical errors, "despite whether it is 98,000 or 40,000 or 20,000. Come look at some of these cases; we need to work on this."

The research team's analysis will not change the message of the IOM report nor will it change future legislation or the way the private sector responds to the IOM report, Diamond says.

The IOM report concludes with a list of recommendations that includes creating a Center for Patient Safety within the Agency for Healthcare Research and Quality. Initial funding of $30 million to $35 million would permit the center to conduct activities in goal setting, tracking, research, and dissemination, according to the report.

Another component of the plan is mandatory reporting of errors. While 23 states (18 of which

require hospital reporting) currently have mandatory reporting systems to track medical errors, President Clinton's plan will have a nationwide, state-based system in place within three years.

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Billing for drugs could become safety issue

A rule implemented Aug. 1 by the Health Care Financing Administration (HCFA) has some pharmacists and other industry insiders concerned about the increased potential for medical errors.

Under the new outpatient prospective payment system, the government will reimburse Medicare services based on the type of procedure performed.

According to **Judy Smetzer**, RN, director of risk management services for the Institute for Safe Medication Practices in Huntingdon Valley, PA, some medications used in affected procedures will be eligible for "pass-through" reimbursement using HCFA J-codes corresponding with specific drug quantity billing units.

Smetzer says that to use the new billing process, some pharmacies may need to change their computer billing and inventory systems in a way that could compromise patient safety.

Pat Minard, PharmD, pharmacy manager at Shawnee Mission (KS) Medical Center, says about 300 drugs will be impacted by the new rule, and depending on a pharmacy's computer system, there could be some problems.

For the 300 or so drugs affected, Medicare will reimburse based on specific doses. For example, Medicare will pay for meperidine in 100 mg units. It is produced in units of 25, 50, 75, and 100, and is typically prescribed in units of 50 mg. "But we have to bill them in 100 mg units so we have to charge them for 100, even though we might use 50," he says.

The problem occurs if the patient returns for a refill and the pharmacist or technician reads the bill rather than the prescription, the patient could receive an overdose. In other cases, Minard says there are drugs that Medicare will reimburse in 5 mg doses. "If you prescribe 30 mg, you have to bill them six times," he says.

Smetzer says multiple billing could desensitize nurses and pharmacists to an important error-prevention rule, "always check when more than two or three units are required for each dose."

The new system could create a problem for automatic software pricing and clinical updates as systems are automatically updated through a software system tied to each drug's national drug code (NDC). "If hospitals create new inventory items to match billing units, it may not be possible to load important software updates since the HCFA dosing units will not have an NDC," Smetzer said.

Since adding or changing drug files and the related units of measure may increase the risk of error, Smetzer recommends finding other ways to accommodate the new billing system. "It may be possible to work with your information system vendor to develop rules by which affected drugs will be intercepted between the clinical and financial sides and the units will be converted into compatible units of measure for billing purposes," she says.

For more information, contact:

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To read the rule, visit the HCFA Web site at www.hcfa.gov. ■