AMERICAN HEALTH CONSULTANTS®

HOSPITAL CASE MANAGEMENT™

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

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IN THIS ISSUE

New collaborative tool helps case managers track diabetes patients

AMA, JCAHO, and NCQA combine forces

For the first time, organizations representing physicians, health plans, and hospitals have collaborated in the development of a common set of evidence-based measures for evaluating performance in health care. Experts say case managers can use these new protocols as a measuring stick for diabetes patients.

The American Medical Association, the Joint Commission on Accreditation of Healthcare Organizations, and the National Committee for Quality Assurance (NCQA) have jointly established broadly applicable measures for the management of adult diabetes. The new tool, called the Coordinated Performance Measurement for the Management of Adult Diabetes, lays the groundwork for testing a single-source approach to measuring performance of care provided to diabetes patients in multiple settings. Development of the document was led by a diabetes expert panel composed of clinical leaders and advisors in diabetes care.

Panel member **Tim Kresowik**, MD, principal clinical coordinator at the Iowa Foundation for Medical Care in Des Moines, says the central aim is standardization of various types of measures. "Unless measures are standardized to the point where people are using the same definitions, exclusions, and patient inclusion criteria, it is very difficult to compare what may seem on the surface to be the same measure," he explains.

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COMING IN FUTURE ISSUES

- An in-depth look at a variance tracking success story
- What does the bear market mean for your hospital?
- Handling HIPAA's privacy rules: What you need to do now
- Measuring the impact of case management interventions
- Values and ethics in case management

According to Kresowik, the measures essentially are designed as a series of performance measures collected at the physician level, which can act as a measure of the quality of the care patients receive for diabetes. For example, one primary measure would gauge whether recommended diagnostic testing was performed adequately.

Case managers with a certain number of patients they are monitoring can use this tool as a "measuring stick," says Kresowik. While the measures are targets at the physician office level, the measures also are applicable to ambulatory clinics associated with hospitals, he says.

In fact, Kresowik says, staff at the nurse level with a set of patients whose care they are helping to manage can apply these measures. "If you are talking about diabetes case management, I think it would be very appropriate," he says. What is required in those cases is an adequate comparison of performance, whether it is a comparison to non-case management or among case managers, he adds.

Kresowik points out that most existing measures have been hospital-based measures. "Most of the types of performance that are being looked at are inpatient." Two additional measuring sets, one dealing with the care of ambulatory patients with coronary artery disease, also are under development, he adds.

Judy Homa-Lowry, president of Homa-Lowry Healthcare Consulting in Canton, MI, says that how useful these new measures are for hospitals will turn on the model the hospital is using. But many hospital-owned physician offices are beginning to do more care management in the office, she notes. "That can be helpful, especially if a hospital is having problems with direct admissions from physician offices."

Typically, she says, attempts are made to address that problem by placing a nurse in the admitting department or performing care management in the emergency room. It requires a fair amount of education, she says. But increasingly, hospitals are designing education programs for their outpatient departments in an effort to keep staff trained and monitored to reduce inpatient stays.

According to Homa-Lowry, Joint Commission performance measures in other areas also are beginning to take on a broader scope than those currently measured for ORYX. "Even if it is directed at inpatient issues, they also want to see how the hospital-owned outpatient facilities would be part of the process," she explains.

For example, if a hospital selected measures for

cardiac care and had a cardiac clinic, it would want the cardiac clinic to have access to the data in order to determine what changes could be made in the outpatient program that might limit inpatient and reduce readmissions, she says. "It is really becoming a continuum of care issue."

According to Kresowik, collaboration among the various groups was critical in the development of these measures. "People have talked for a long time about trying to come together and develop some standardization," he says. These measures also are very close to measures established by the Health Care Financing Administration (HCFA). Ideally, HCFA, the Joint Commission, and NCQA eventually will adopt the same measures, he adds.

Some previous attempts to establish measures in the treatment of diabetes have resulted in "arbitrary thresholds," argues Kresowik. "It is a real challenge when you are trying to ascribe that to the performance of the physician, because much of the patients' diabetes control relates to the patients' compliance with their therapy. If you have very highly motivated patients who follow instructions, take their medication, and follow their diet, they will have a good result," he explains.

In other cases, the physician may do everything correctly but the patient is not as compliant and may wind up with a less favorable result. However, those more closely resemble "intermediate outcomes measures" as opposed to "process measures," such as ordering a certain diagnostic test, which the physician has far more control over, Kresowik says.

"When you measure intermediate outcomes, you have to take into account the role of the patient more heavily," says Kresowik. In those cases, these measures display results in a fashion that lets hospitals compare the distribution of patient results to other hospitals without arbitrary thresholds about what constitutes a "good" or "bad" result.

The new measures are designed to be available for physicians to measure themselves against others with the involvement of the Joint Commission and NCQA to increase accountability, Kresowik says. "You want to be able to measure at a physician level because that is ultimately where the organization is going to succeed or fail."

When some of the measures are reduced to the physician level, it may be difficult to make adequate comparisons, he warns. "When you start talking about a handful of patients, it is difficult to make comparisons.

"Nevertheless, ultimately that is the level that is aggregated up to the organization level," he adds.

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CM can play critical role in reducing medical errors

NJ hospital takes process improvement approach

These days, virtually every hospital in the country is actively engaged in finding ways to reduce medical errors. Now, many are catching on to the fact that case management can play a pivotal role in this pursuit.

The role of case managers in reducing medical errors is critical, says **Michelle Gofney**, director of case management at Deborah Heart and Lung Center, a 161-bed hospital with a full-service ambulatory care center in Mills, NJ. This year, Deborah Heart and Lung implemented an ambitious medical error reduction program.

"Case managers are the primary specialty voice to reduce medication errors," explains Gofney. Managers look at the patient's medical care through the physician's eyes and the nurse's eyes as well as every ancillary department in the hospital, she adds. "They are the hub of the whole planning process."

Deborah was established in 1922 as a tuberculosis sanitarium and pulmonary center. After the development of antibiotic medications, the facility expanded its focus to other chest diseases. It added the specialty of cardiac diseases and evolved into the only cardiac and pulmonary specialty hospital in New Jersey. Today, Deborah offers surgical techniques and nonsurgical alternatives for diagnosing and treating all forms of cardiac, vascular, and pulmonary diseases in adults and congenital and acquired heart defects in neonates and children.

As a means of re-enforcing its ongoing effort to develop and maintain a "culture of safety" for both patients and staff, the Deborah Heart and Lung Center and the Deborah Hospital Foundation's executive boards recently adopted a resolution that supports that commitment. The centerpiece of the

resolution is a series of recommendations and directions of leadership, according to **Carolyn Magnotta**, RHIA, CPHQ, director of process improvement, who is responsible for managing the effort.

To more effectively coordinate and streamline medical error reporting, Deborah established six groups: Adverse Drug Event Steering Group; Incident Report Subcommittee; Peer Review Committee; Process Variance Team; Pharmacy & Therapeutics Committee; and the Ad Hoc Committee. The full scope of the organization's medical error reporting efforts then was outlined in a medical error reporting grid.

Each group was charged with achieving specific goals. For example, the Incident Report Subcommittee was tasked with developing an organizationwide incident reporting policy, which incorporates patient occurrences, employee occurrences, visitor occurrences, and security breaches as well as property loss or damage.

The Incident Report Subcommittee also was responsible for designing root-cause analysis for high-volume/high-risk occurrences to include musculoskeletal injury, patient falls, chemical or mechanical burns, infusion therapy injuries, medication administration, and monitoring errors, as well as skin breakdown injuries.

The subcommittee also reviews and analyzes aggregate data for trends over time, supports education on reporting and investigating incidents, and recommends process improvement opportunities to the environment of care committee and QIC.

One major focus of many of the groups is medical error reporting, since a significant number of medical errors are attributed to this area. Multidisciplinary committees then are tasked with reviewing and analyzing all "unusual events" that either cause or have the potential to cause serious injury.

According to Magnotta, the Adverse Drug Event policy was revised to include definitions for medication error vs. adverse drug reaction. The policy also outlines reporting procedures, with all errors categorized to meaningful trending and analysis of reported events. In addition, a specific medication incident analysis report form was developed to assist in the reporting process, she adds.

In order to assess the current environment, the caregiver's perception of the "culture of safety," and the ease in reporting, Deborah distributed a survey to all clinical staff and physicians in March. The set of 13 questions specifically addresses the perception these two groups have about the commitment of senior managers in the organization to communicate the importance of patient safety and facilitate adverse event reporting as well as the extent to which appropriate technology is employed to support that aim.

Magnotta reports that the response was fair. Results of the questionnaire were generally favorable, with the majority of respondents indicating that patient safety is a high priority. Respondents also reported that medical errors generally are reported and staff that do so receive support within the organization, she says.

The response that troubled the steering group the most was that a large number of respondents did not agree that a medical error is the result of a failure of a complex system when, in fact, data show that errors are most often precisely that. Deborah plans to address this problem through education at inservices, which will include all clinical staff.

According to Magnotta, the program outline includes an introduction from the executive director regarding the board resolution as well as administrative support for an environment of safety. The revised policy and tools for reporting will be reviewed and discussed, and survey results will be shared. Attendees then will be asked to participate in an activity demonstrating the impact of systems issues along with recommendations about how to evaluate systems and improve processes.

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Standardized treatment cuts pneumonia deaths

Guidelines also help lower admission rates

Death rates and hospital admissions for patients with community-acquired pneumonia were reduced significantly by using standardized treatment protocols developed in Utah. The results of the five-year study of more than 29,000 Utah pneumonia patients were published in the April 16, 2001 issue of the *American Journal of Medicine*.[1]

A multidisciplinary team at Intermountain Health Care (IHC) in Salt Lake City, began establishing the treatment guidelines in 1994, notes **Nathan Dean**, MD, pulmonary medicine specialist at IHC's LDS Hospital, also in Salt Lake City, and the study's principal investigator. Dean also chairs IHC's lower respiratory tract infection team.

"We had representatives from a number of different specialties, in both rural and urban facilities. They included emergency departments [EDs], family practitioners, pharmacy, respiratory therapists, nursing, administration, and pulmonary and infectious disease physicians," he says.

Prior to the establishment of the guidelines, treatment varied widely from facility to facility, where in some cases nearly 70 different oral and intravenous antibiotics were being used to treat pneumonia patients, with no correlation to optimal clinical outcomes.

Standardizing the risk assessment

The key to the new clinical guidelines was a standardized risk assessment based on age, history, coexisting illnesses, and physical and lab abnormalities. Patients with fewer than two risk factors were recommended for outpatient oral antibiotic treatment. Those with two or more risk factors were evaluated for hospital admission or outpatient treatment with additional therapy.

At the time, the only existing published guidelines for the selection of antibiotics were those of the American Thoracic Society (ATS), Dean notes. "We simplified their guidelines and made them more operational, with bows to local practice," he says. For example, there was a common practice of using an injectible antibiotic, ceftriaxone, especially in rural facilities. "At the time, it was not recommended by the ATS," Dean recalls. "When we looked at it, it seemed to be a very good practice that was consistent with the guidelines, although not part of them."

Interestingly, the new ATS guidelines do include ceftriaxone. "Some of our work helped validate certain treatments, and some have found their way back to the revised guidelines," Dean observes. Antibiotic selection was organized according to those medications that cover common pathogens. In addition, it was decided to administer them as soon as possible after diagnosis. "Administration is now initiated in the [ED], or the urgent care center, rather than admitting the patient and waiting several hours for the first dosage," he explains.

Admission decision support was based on objective risk stratification. "This gives an objective measure of what the patient's risks of severe disease are," Dean explains. Routine preventive treatment against pulmonary embolism also is implemented.

The researchers observed the pneumonia patients over a five-year period. Thirty-day mortality was 13.4% among admitted patients and 6.3% overall, and was similar among patients affiliated with IHC and those not affiliated before the guideline was implemented. For patients admitted after guideline implementation, 30-day mortality was 11% among patients treated by IHC-affiliated physicians compared with 14.2% for other Utah physicians.

"That was a statistically significant finding," Dean says. "Another variable outcome we looked at was admission rates, where there was a pretty good odds ratio (0.89) trend toward decrease. Length of stay also had a decrease statewide, although it was not statistically significant."

Dean notes that the guidelines have changed over time, as new literature about antibiotics is published, and as more information is gathered around the region. "They also are linked with contracting by our system," he adds. "If two medications are comparable by efficacy, the less expensive one is chosen."

Administration guidelines also have evolved. In 1997, it was determined that a patient with fewer than two risk factors would be recommended for outpatient oral therapy. That changed to three risk factors in 1998. "Doctors were not admitting patients with two risk factors, and they were treating them successfully as outpatients," Dean adds. "Since they were doing so well, there was no need for us to try and change the practice."

The relationship between outcomes and changed guidelines was covered in a paper in the May 2000 *Chest*,[2] which Dean co-authored. "[Guideline] committees tend to be conservative," he explains. "It's important as you put these guidelines out and get experience, that you get feedback from the physicians in your system, look at your own data, and make changes when appropriate. You don't want to butt heads with docs, particularly when they're right."

The results of the study seem once again to underscore the importance of standardization in a medical setting. "Everyone knows there is tremendous variation in medical practice," says Dean. "But some ways of doing things are clearly better than others. That's particularly true with diseases like pneumonia, which is mostly treated

by primary care doctors who may not be up on the latest information or developments. Recommended practice patterns can help guide them toward the most effective treatment. One of the problems with most national guidelines is that they are too long; we made them much more simple and more directive."

No set of guidelines should be seen as carved in stone, he adds. "We assume physicians will vary from the guidelines when they feel it is clinically appropriate," he declares. "Compliance with our guidelines in the year 2000 was 85%, which is just about where we want it. Practices should vary, to some degree. It's like a recipe; if you're making stew, you need something to guide you, but you also need to be able to vary from the recipe."

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References

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2. Dean NC, Suchyta MR, Bateman KA, Aronsky D, Hadlock CJ. Implementation of admission decision support for community acquired pneumonia. A pilot study. *Chest* 2000; 117:1,368-1,377. ■

CE questions

For your convenience, *HCM* will be printing CE questions in each issue, beginning this month. Subscribers will receive a complete test and Scantron sheet in December 2001.

1. Which of the following organizations did not participate in developing the Coordinated Performance Measurement for the Management of Adult Diabetes?
   A. The American Medical Association
   B. The American Nurses Association
   C. The Joint Commission on Accreditation of Healthcare Organizations
   D. The National Committee for Quality Assurance
2. Name the group at Deborah Heart and Lung Center in Mills, NJ, tasked with designing root-cause analyses for high-volume/high-risk occurrences.
   A. Incident Report Subcommittee
   B. Adverse Drug Event Steering Group
   C. Peer Review Committee
   D. Ad Hoc Committee
3. In a five-year study of pneumonia patients conducted by Intermountain Health Care in Salt Lake City, what was the overall mortality percentage?
   A. 2.4%
   B. 5.7%
   C. 6.3%
   D. 8.9%
4. List the number of new cancer cases per year at the Regional Cancer Center in Waukesha, WI.
   A. 600 to 699
   B. 700 to 799
   C 800 to 899
   D. 900 to 1,000

NEWS BRIEFS

Follow-up care reduces costs in high-risk infants

A program of comprehensive neonatal follow-up care after hospital discharge for inner-city high-risk infants reduces life-threatening illnesses and appears to reduce medical costs by more than $3,000 per infant as well, according to a study published in the *Journal of the American Medical Association*. Researchers at the University of Texas Southwestern Medical Center at Dallas found that when high-risk infants received comprehensive follow-up care, 47% fewer of them died or developed life-threatening illnesses that required admission for pediatric intensive care. High-risk infants were defined as those weighing less than 1,000 g at birth or those weighing 1,001 g to 1,500 g who required mechanical ventilation.

Comprehensive follow-up care for high-risk infants was defined as 24-hour access to highly experienced caregivers and five-day-a-week follow-up care, which included well-baby care, treatment for acute and chronic illnesses, and routine follow-up care. Routine follow-up care was available two days per week and included well-baby care and chronic illness management.

For all care between discharge and one year, the

(Continued on page 111)

CRITICAL PATH NETWORK™

Improve patient safety to comply with new standards

Demonstrate evidence to JCAHO surveyors

In one emergency department (ED) recently, **Kathleen Catalano**, RN, JD, was shocked to notice pharmacists refilling five vials of potassium chloride (KCl). "I asked about the fact that concentrated potassium chloride was being put out for use," she recalls.

Catalano, who is director of administrative projects at Children's Medical Center of Dallas, learned that ED nurses had prepared an IV with KCl without calling in pharmacy, as the hospital's policy required. To make matters worse, the IV was not prepared under the laminar airflow hood — another violation of hospital policy.

"The pharmacy technician was not the least bit alarmed about the use of concentrated KCl," she says. "There, but for the grace of God, went a medication nightmare." KCl is often mistaken for other medications such as sodium chloride, heparin, or furosemide, and direct infusion of concentrated KCl results in death, she explains.

Concentrated KCl should be removed from all medication areas, including the ED unless specific safeguards are in place, warns Catalano, a former consultant with the Greeley Co., a firm in Marblehead, MA, specializing in health care regulatory compliance.

Dangerous situations like the above scenario have led to the development of new patient safety standards from the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL. The standards become effective July 1, 2001. The patient safety standards are broader than the sentinel event standards which became effective in 2000, according to Catalano. "The new standards look at more than just the patient who has been subject to a catastrophic event," she says.

Recent reports from the Washington, DC-based Institute of Medicine spurred the Joint Commission to focus on patient safety, she adds.

Warning: Avoid these scenarios

Surveyors will be asking what you've been doing to improve patient safety in your ED, according to **Carole Patterson**, MN, RN, consultant for Joint Commission Resources (JCR), an Oakbrook Terrace, IL-based provider of education and consulting services established by the Joint Commission, and former director of the Joint Commission's Standards Interpretation Group.

"Questions about how the hospital is improving patient safety by doing proactive risk identification and reduction activities will be an important part of the unit visits, including the ED," Patterson points out.

Any of the following three scenarios will get you into trouble during a Joint Commission survey, says Patterson:

1. Staff members fail to respond appropriately to surveyor questions about patient safety-related questions.

2. There is no evidence of efforts to reduce safety risks to patients in the ED.

3. The ED is not involved in hospitalwide efforts to improve patient safety.

"Special notice would be taken and written up in the preliminary noncompliance report given to the hospital at the end of the survey," Patterson warns.

Here are ways to comply with the patient safety standards:

(Continued on page 106)

Presbyterian Hospital of Dallas

Alternatives To Restraints/Restraints Flowsheet

Teaching: Need for Restraints; Alternatives; Criteria for Release Provided To:
__Patient __Family __Significant other _See Multidisciplinary Patient/Family Education Trending Record
Response to Teaching:
__Understands need for Restraints __Unable to teach at this time __Family/Significant Other not available

I. BEHAVIOR EXHIBITED
1-Agitated
2-Assaultive
3-Climbing out of bed
4-Combative
5-Harm to others
6-Harm to self
7-Lack of Decision Making Ability
8-Low Level of Consciousness
9-Pulls at Tubes/IV Lines/Dressings
10-Unable to follow directions
11-Wandering
12-Other:_____
13-Per Protocol_____

II. RESTRAINT/IMMOBILIZER TYPE
1-Wrist x1
2-Wrist x2
3-Ankle x1
4-Ankle x2
5-Vest
6-Body Net
7-Chemical
Agent:_____
8-Other:_____

III. ALTERNATIVES ATTEMPTED

Provide Companionship/Supervision
1-Family in Room
2-Sitters
3-Provide 1:1 attention

Modify Environment
4-Add padding/wedge pillows
5-Bed Alarm
6-Decrease/Remove Stimulus
7-Hide tubes under binder
8-Geri-chair
9-Call light accessible
10-Move close to RN Station
11- Provide consistent Caregiver Assignment
12-Reposition/Stockinet tubes
13-Task Segmentation
14-Wear Non-skid Socks

Reality Orientation
15-Frequent Cueing/ Reminding
16-Involve patient in conversation
17-Redirect Behavior
18-Use Relaxation

Diversional Activities
19-Provide Exercise
20-Use Activity Apron
21-Use TV or Music

Other
22-Assess underlying Med Problems
23-Consult with other Disciplines as needed
24-MedReview/Modification
25-Pain Relief
26-Comfort Measures
27-Per Protocol _____

IV. WHY ALTERNATIVES FAILED
1-Unable to follow directions
2-Behavior unchanged
3-Lack of decision making ability
4-Low level of consciousness
5-Unable to assess orientation

V. ASSESSMENT OF PERSONAL NEEDS
A=ALL LISTED
Call Light available
Food/Liquid Offered
Pain Assessment
Repositioned
Emotional Needs
Skin Integrity
Respiratory Status assessed
ROM performed
Skin circulation assessed
Toileting offered

VI. CONTINUED NEED FOR RESTRAINTS
1-Yes
2-No Longer Exhibits behavior requiring Restraints
3-Temporary Release: Family in room *SEE Nurse's Notes
4-Temporary Release: Nurse in room *SEE Nurse's Notes
5-Other:_____

Date	Time	I. Behavior Exhibited	II. Restraint/ Immobilizer Type	III. Alternatives Attempted	IV. Why Alternatives Failed	V. Assessment of Personal Needs	VI. Continued Need for Restraints	Initials
	0800							
	1000							
	1200							
	1400							
	1600							
	1800							
	2000							
	2200							
	0000							
	0200							
	0400							
	0600							

IN	Signature	IN	Signature	IN	Signature

Source: Presbyterian Hospital of Dallas.

Organization Name
Address
Town, State

Conscious Sedation Documentation Flow Sheet

Date: _____ Department: _____ Addressograph: _____

Physician Section: Anesthesia Assessment

Pertinent past and present **medical** history:

_____

_____

r See H&P, comprehensive note or progress

Pertinent past and present **medication** history:

_____

_____

r See H&P, comprehensive note or progress

ASA Classification: r I. Healthy patient r II. Mild systemic disease, no functional limitation r III. Severe systemic disease, definite functional limitation. r IV. Severe systemic disease that is a constant threat to life r V. Moribund patient not expected to survive 24 hrs.

Results of relevant diagnostic studies: r N/A

_____

Plan of anesthesia: r Conscious sedation r Other: _____ **Risk/Options discussed**: r Yes r No _____

Physician Signature: _____

I. Nursing Personnel Section: Pre-Sedation Assessment Flow Sheet r See Nursing Assessment

Age: _____ Sex: r Male r Female Weight: _____ Temp: _____ P: _____ R: _____ BP: _____ SaO2%: _____ Pain: _____

ID Bracelet on: r Yes r No Dentures/bridge removed: r Yes r No r N/A Cardiac Rhythm: _____

Allergies/Reaction: _____

Procedure to be done: _____ Performed by: _____ MD Monitored by: _____ RN

Patient Outcomes—If no, explain

Patient will demonstrate knowledge of the planned procedure r Yes r No _____

Consent forms signed, dated and witnessed r Yes r No _____

Patient expresses an understanding of the procedure r Yes r No _____

IV Therapy

Time	Size	Site	Site condition	Solution	Amt in Bottle	Started by	Comments
	r Arrived with IV	r Arrived with Saline lock				N/A	

ALDRETTE SCORE KEY:		Level of Consciousness [LOC] KEY
Activity: 2 Able to move 4 extremities voluntarily or on command 1 Ablet o move 2 extremities voluntarily or on command 0 Able to move 0 extremities voluntarily or on command	**Pulse Oximetry:** 2 > 92% on room air 1 Needs oxygen to maintain 92% 0 < 92% with oxygen	1 = Alert and oriented 2 = Mild sedation, oriented, able to answer questions 3 = Moderate sedation, easily arousable, maintains patent airway, responds to physical/verbal stimuli
Respirations: 2 Able to deep breathe and cough freely 1 Dyspnea or limited breathing 0 Apneic	**Consciousness:** 2 Answers questions appropriately/aware of location 1 Arousable on calling 0 Not responding	4 = Deep sedation, depressed consciousness, NOT easily aroused but maintains patent airway. 5 = Deep sedation, unconscious, unarousable, possible partial or complete loss of ability to maintain patent airway
Circulation: 2 BP = 20% of pre-sedation level 1 BP = 20-49% of pre-sedation level 0 BP = 50% or greater of pre-sedation level		

Revised: December 2000

Source: Cheshire Medical Center, Keene, NH.

(Continued from page 103)

• **Use alternatives to restraint.** You'll need to be familiar with Joint Commission standards for the least restrictive use of restraints, both physical and chemical, and be able to answer surveyor's questions about those standards, says **Kathryn Perlman**, MS, RN, clinical educator for the ED at Presbyterian Hospital of Dallas.

Surveyors will ask nurses what documentation is required for a patient who is restrained, what are alternatives to restraints, and how often a patient who is restrained needs to be reassessed, she says.

At Presbyterian, ED nurses are required to complete a form showing that alternatives are being attempted. Perlman suggests decreasing stimulation by dimming lights, turning off the TV or radio, moving the patient to a room close to the nurses' station, or using bed alarms. **(See Alternatives to Restraints/Restraints Flowsheet, p. 104.)**

• **Be involved in your hospitals' patient safety program.** Patterson advises joining the hospital's patient safety or environment of care safety committee. "Bring along one of the ED physicians, too," she suggests. "Medical leaders are key to making patient safety efforts visible as well as viable."

• **Order IV admixtures from pharmacy.** Having the pharmacy mix IVs eliminates the need to keep the admixture drug on the unit, says Perlman. "It adds another risk-control element because the pharmacist checks it before it leaves the pharmacy," she explains.

• **Do not keep bottles of multidose drugs on the counter.** Examples of multidose drugs include Tylenol elixir and Prelone, says Perlman. "Joint Commission hates this, and it's dangerous," she underscores.

"Having medications lying around the room makes it easy to grab the wrong bottle, thinking that it is something else, if the bottles look alike, for example," adds Perlman.

• **Apply conscious sedation standards consistently throughout the hospital.** You must apply the same protocol in any area that uses conscious sedation, says **Cheryl Pinney**, RN, BSN, MBA, director of emergency services at Cheshire Medical Center in Keene, NH, and the hospital's Joint Commission coordinator. **(See Conscious Sedation Documentation Flow Sheet, p. 105.)**

"This is not a new standard, but there still continues to be a lot of focus on this area,"' she says. "Along with using a consistent protocol, staff must be trained to use the protocol."

The key is that all areas follow the same protocol, says Pinney. She suggests having several training sessions scheduled at various times that all staff attend, inservicing at staff meetings, developing self-study packets with a simple post-test, or implementing a poster campaign in a clinical area that all staff sign off on.

• **Have your hospital risk manager perform an inservice for your staff.** At Cheshire Medical Center, the hospital risk manager provided a half-hour presentation to ED nursing staff on sentinel events and how to perform a root-cause analysis.

Pinney included information in the staff meeting minutes for staff who were unable to attend. "We also will review components of the presentation at future staff meetings," she says.

• **Perform a visual inspection.** Check for evidence of safety issues in your ED, recommends Pinney. Here are some examples she provides:

— Look around for mishandled items, such as a syringe left in an inappropriate place.

— Make sure that supply cabinets and crash carts are locked.

— Be sure that cabinets and storage areas are clean and items are appropriately stored.

— Inspect white boards to see if there is any breach of confidentiality.

The ED uses a department checklist of items to review before surveyors arrive, says Pinney.

• **Make sure that checklists are up to date.** There should be "no holes," says Pinney. The ED staff use crash cart and trauma room checklists once every 24 hours, and obtain replacements as needed.

"Staff are held accountable to make sure no day is missed in checking the lists," she says.

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How to define risk factors among cancer patients

"How do you identify patients who are most at risk when all of your patients have cancer?" That's the question posed by **Mary Gilbert**, BSN, CCM, oncology care coordinator at the Regional Cancer Center in Waukesha, WI.

"There must be one or two triggers that will identify someone as being at more risk," Gilbert says. "Many of the traditional identification systems we're struggling with because everyone we see has cancer."

Another part of the challenge, she adds, is to better define the facility's more global care management. The Regional Cancer Center serves two hospital campuses, one of which — a 275-bed facility — has a dedicated oncology unit of 15 beds, four of which are designated for stem-cell transplants. The other hospital, which has 130 beds, cares for oncology inpatients on a medical-surgical unit. Both hospitals have outpatient medical and radiation clinics for cancer patients.

"We have about 900 to 1,000 new cancer cases per year," Gilbert notes.

The Regional Cancer Center currently has no formal case management program, but it does take a care management approach in selected areas, Gilbert explains. For instance, a nurse practitioner is dedicated to coordinating the care of patients undergoing peripheral stem cell transplant, leukemic/hematological patients, and other clinically complex patients.

A coordinator at the Center for Breast Care navigates women through the system from suspicious mammogram through biopsy, initial treatment, and supportive follow-up, she notes. Another professional supports men through the diagnosis and treatment options for prostate cancer. Most recently, Gilbert says, a palliative care coordinator has been added. That coordinator identifies, assesses, and supports patients for whom treatment is not expected to result in a cure, she adds. "We are still deciding how long and to what degree [the palliative care coordinator] will follow those patients."

The nurse practitioner who works with the stem cell transplant patients stays with them throughout their care, Gilbert notes. The coordinators who work with the patients who have breast and prostate cancer, however, are involved primarily in the diagnostic and early treatment phase of care. After that, she adds, those patients' care is overseen by Gilbert and the other oncology care coordinator.

"The biggest question revolves around the majority of other patients — how to identify who is at risk and/or who needs case management, and to help patient and family through different referral systems," Gilbert says.

A few years ago, Gilbert began screening for certain risk factors. Those included: an elderly person with cancer who's the caregiver for his or her spouse; someone on multiple medications; and someone with multiple comorbidities.

That quickly resulted in more referrals than she could case-manage, Gilbert adds. "What's evolved is that I'm just putting out fires." For example, she's called upon to act as a liaison when a person whose cancer has recurred appears to be headed for a hospice. Or she is asked to provide mental health support or counseling for a family that isn't coping well, or to investigate a reimbursement failure.

Gilbert and another care coordinator do all the discharge planning on the inpatient unit and communicate with the outpatient clinic on patient care, she says. "That piece won't go away." The question is how to identify the minimum level of care that all patients receive, and then to identify

those who need more, Gilbert adds.

"What we'd like to do is determine more proactively who is at risk and needs more care management, more intensity of service," she says. "We'd like to head off problems sooner."

Another issue is determining how to divide the work between Gilbert and the second oncology care coordinator in a manner that best meets the needs of all oncology patients, she notes.

She says the cancer center is interested in a system where the nurse who works most closely with the patient can do an initial assessment and reassessment and, based on that, contact the other members of the care team.

"We don't want a system where every patient is reviewed, because it's not humanly possible," Gilbert adds. "I'm curious as to what other models people have tried and found workable."

RESPONSE

*(Editor's note: **Jackie Birmingham**, RN, MS, CMAC, is a veteran discharge planning and case management consultant who is vice president of clinical design for Curaspan Inc., an application service provider based in Needham, MA, that develops technology for connectivity and information exchange between health care providers. She was named "Case Manager of the Year" for 2000 by the Little Rock, AR-based Case Management Society of America. In the response below, she offers suggestions for developing a case management model at the Regional Cancer Center.)*

Casefinding and screening are hallmarks of case management, whatever the setting or patient diagnosis. In the situation described on p. 107, all the patients have met one of the cardinal criteria: They have cancer. However, further stratifying the criteria into priority categories will be necessary.

One category for establishing a priority ranking is to use a functional health pattern assessment. Rather than looking at the diagnosis specifically, looking at how the patient is functioning should be helpful. Of particular importance is the patient's ability to manage his or her own self-care needs, nutrition and activity.

A very basic screening of activities of daily living and instrumental activities of daily living will give the case manager an idea of where support is needed and what kind of support.

Looking at the way Gilbert described her role, there are a few points that can be considered:

1. All patients need to be screened in some manner. Her three screening criteria are good, but she may want to look at the criteria in combination with the functional assessment. Some patients are amazing in that they may meet all three (elderly and a caregiver, multiple medications, multiple comorbidities) and still be functional for a period of time. One cancer center uses a paper and pencil self-assessment tool when a patient is admitted to service. It is similar to other nursing-based assessment tools in that it gives a baseline of all the systems from skin to gastrointestinal, but it provides a more holistic approach. Anyone who admits the patient to the center can complete the form, and there are specific triggers for a referral.

2. Collaboration with all professional staff available to the patient needs to be developed. It appears that there are various health professionals whose roles are to provide a level of service to cancer patients. A clear delineation of role functions and where they are performed will be helpful, not only to Gilbert, but to the other professional staff. Some examples of partnerships are:

- Gilbert mentions that she is asked to provide mental health support or counseling for a family that isn't coping. This is more appropriately done by a social worker or a clinical nurse specialist.
- The oncology care coordinators also act as liaisons with the hospice service. This may be another instance where someone in a different area can support Gilbert's efforts. Nurses or social workers from a hospice may welcome the chance to provide coordination for their patients while they are hospitalized. The clinic staff will welcome the opportunity to get consistent feedback from the hospice on the status of their patients.
- They also are asked to do discharge planning for inpatients in the unit with 15 beds. It is important that the case manager work with the nurses and / or social workers assigned to that unit since they will probably be the ones seeing the patient's family and coordinating care between more than one physician, both while the patient is hospitalized and when he or she returns home.
- They do case management for two clinic settings and one hospital unit. There needs to be some method of coverage for these distinct units that will eliminate the need for frequent travel, which equates to lost time.

Maria Hill, RN, MS, senior consultant with The Center for Case Management in South Natick, MA, suggests that the assignment be divided, with one person assigned to discharge planning for inpatients and the other to the clinics. Depending on the volume of patients in each unit, this is a consideration.

One recommendation for enhancing the

collaborative model of case management is to develop an interdisciplinary care team. In some areas, weekly interdisciplinary meetings are held to discuss patients' progress. Members of this type of team ideally include a hospice nurse, clinic nurse, dietitian, social worker, pastoral service representative, and a physician.

The staff from the care center, including the clinical nurse specialists for the breast and prostate cancer patients, the stem cell coordinator, and the palliative care team coordinator should regularly attend these meetings. Sometimes therapists — physical, occupational, and speech — also attend the meetings. For centers that treat children, a liaison from the school system also might be asked to attend.

These meetings should be held weekly, with a rotating chairperson, and minutes. The chairperson would be responsible for the agenda and for keeping the meetings short and to the point. If there is a patient who is in crisis, the primary caregiver should call a separate patient care conference.

My suggestion is that the care coordinators for breast and prostate cancer follow their own patients through the course of treatment, because the patient and the family need continuity of providers. Gilbert should act as consultant to these care coordinators as they take on the complete role of following the patient through the episode of illness. The functioning of the person who does the stem cell coordination can be the model for care coordination.

3. Communicating with external sources is another focus of case management.

• Contacting payers for payment questions (utilization review).

• Contacting referral sources, community agencies, transportation services.

• Working with families to determine the needs of the patient at home.

• Keeping the flow of information going between the inpatient and outpatient service. (The case manager may be the only person who knows the patient's story.)

• Assuring all the legal duties regarding discharge planning are followed, all the ethical duties of patient choice are followed, and all standards of practice are met requires a great deal of work.

Gilbert needs a stronger network of collaborators inside and outside the organization. A look at the job from the perspective of a collaborative framework probably will give a clue as to ways to manage such a significant list of duties and responsibilities. Looking at the numbers of patients and the numbers of points of contact also will provide data for determining what needs to change.

The question Gilbert asks is a good one, and it is not unique. Outpatient centers all over the country are struggling with ways to care for patients in the new health care environment. The change in reimbursement to outpatient centers as a result of the ambulatory payment classifications, the incentives to decrease lengths of stay, and the desire of the patient and family to be at home during a critical time all add up to more pressure to manage care more efficiently. There are many like Gilbert who are struggling to do a good job in very restrictive environments.

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'Payer specialists' save nurses time

New UR requirement sparks innovative solution

When Birmingham's Montclair and Princeton Baptist Medical Centers — along with other Alabama hospitals — had the utilization review (UR) function delegated to them by Blue Cross and Blue Shield of Alabama, one of the stipulations was that nurses must perform the review.

"We certify or noncertify admissions based on Blue Cross/Blue Shield criteria, and Blue Cross conducts a quarterly audit to verify our UR activity," explains **Laurie Gautney**, RN, MSN, CMAC, director of case management.

That meant that a few employees who were certified in health information management and had been performing the UR function for years could no longer serve in that capacity, Gautney says. "They were great reviewers, but Blue Cross mandated that nurses perform UR after a certain date."

One of the recommendations of a consultant hired by the hospitals to do an assessment of productivity and jobs was to delegate certain functions that do not require specific certification, she says. The hospitals followed this suggestion and, as a result, the registered nurse UR coordinator can spend more time doing functions that require her skills and licensure, Gautney notes.

The hospital administration devised a plan that makes use of the former reviewers' skills and

enables the nurse case managers to perform their duties more efficiently, she adds.

Now known as "payer specialists," the employees make calls to insurance companies to get the necessary approval for patient stays, freeing up the case managers to do more direct patient care, Gautney notes. The nurses all have caseloads of between 35 and 40 patients each, she adds, and while not all cases require insurance intervention, most do.

It works as follows, Gautney says: For every patient who is admitted, a face sheet is printed and sent to the payer specialists, who are equipped with headsets and personal computers.

"They look at [the face sheet] and say, 'This is XYZ insurance, and I know we need to get a review in,' so they contact the case manager, who performs the review and sends it back via e-mail," she explains. "The payer specialist will call the insurance company, let it know what's going on, and receive certification for, say, three days."

Keeping in touch

If, for some reason, the payer specialist needs additional information while on the telephone with the insurer, she will e-mail or page the case manager, Gautney notes. "We use a lot of technology. All my case managers have alpha pagers, which means not only the phone number, but the message comes across. The payer specialist can page a case manager and ask, 'What is the patient's temperature today?'"

These employees — there are 3.5 full-time equivalents — are stationed in a room in one location that serves three hospitals, she says. "They all have access to the same computer systems, and we send things to one group e-mail. They all get the information, so we don't have to worry if one is off that day."

"Everything is dependent on the payer contract," Gautney points out, and "another benefit to these [payer specialists] is that they're familiar with all that. It keeps us out of the precert denial range."

Before this system was put in place in early 1999, she says, the case managers would have to determine which patients they needed to review, go and review those cases, and then call the insurance company to get certified days. "They would have to wait on hold, or leave a message and [the insurance company] would call back and miss them," Gautney adds. "It took a long time just to do one review."

Another plus to having someone who sits by a telephone, she says, is that the insurance company likes it. The payer specialist can call United, for example, with all 20 of its cases, rather than handle them separately, Gautney notes.

"It's really been a good thing," she says. "Once in a while, the case managers may have to make a call themselves — maybe because they're working at an odd hour — and they just hate it. They really appreciate what the payer specialists do. It's so time-consuming and mundane."

Because the reviews typically come in about midday, the payer specialists have time to do some precert troubleshooting in the morning, Gautney says.

"We were having some difficulty ensuring that we had the right precert number for patients who are scheduled for surgery, magnetic resonance imaging, or outpatient testing," she notes. "The patients would come in, the admitting people wouldn't stop them — because it's not really up to them — and they would have the procedure. Then the insurance company would say, 'We don't have the precert number,' and wouldn't pay us."

What some people don't realize, Gautney says, is that an insurance company may have authorized a patient's surgery for one date, but if that date is changed, the authorization is no longer valid. "Or maybe a vaginal hysterectomy is certified, but then the physician does an abdominal hysterectomy and is not precerted for that."

What happens now is that the payer specialists get a list of patients scheduled for elective admission or outpatient testing, and call their physicians to make sure a precert number has been obtained, Gautney says. This is typically done about 48 hours in advance of the scheduled procedure, she notes, to make sure that patients don't show up for surgery and discover there is no precert number.

"If by noon today, they don't have a precert number for a procedure that is tomorrow at 6, [the payer specialists] contact the physician's office and try to put it back in their lap," Gautney says. "They don't want their patient angry, so they either get the number or they reschedule. Usually they just get the number."

When there is a problem with the precert, she points out, "the physician's office doesn't usually lose the money — the hospital is out the length of stay." Thanks to the payer specialists, Gautney adds, "we haven't had any [of those losses] in the past two years." ■

(Continued from page 102)

estimated average cost per infant was $6,265 for comprehensive care and $9,913 for routine care.

(See: Broyles RS, Tyson JE, Heyne ET, et al. Comprehensive follow-up care and life-threatening illnesses among high-risk infants: A randomized controlled trial. JAMA *2000; 284:2,070-2,076.)* ■

GOLD standard for COPD released

The National Heart, Lung and Blood Institute in Bethesda, MD, and the World Health Organization in Geneva recently released new international guidelines for diagnosing, managing, and preventing chronic obstructive pulmonary disease (COPD).

The guidelines were a cooperative effort called the Global Initiative for Chronic Obstructive Lung Disease (GOLD), commonly referred to as the GOLD Guidelines. Among other recommendations, the guidelines emphasize the use of bronchodilators for symptom management in COPD.

They state:

• Inhaled bronchodilator maintenance therapy

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Editorial Questions

For questions or comments, call **Russ Underwood** at (404) 262-5521.

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has been shown to improve health status significantly.

• Long-acting bronchodilators are more convenient than alternative treatments.

"The guidelines represent the latest thinking about COPD management and contain important information for both physicians and patients," notes **Stephen Rennard**, MD, professor of medicine at the University of Nebraska Medical Center in Omaha and a member of the expert panel that helped developed the guidelines. "There is clearly a need for better education about this disease and the best ways to manage it. My hope is that the guidelines will help raise awareness and improve the quality of care and the quality of life for people living with COPD."

More information on the guidelines is available on www.goldcopd.com. ▼

Better education may reduce back surgery rates

Back surgery rates in the United States are rising rapidly, according to the Agency for Healthcare Research and Quality in Rockville, MD. A recent study in *Medical Care* finds that an interactive video helps patients make better decisions about whether or not to undergo elective back surgery.

Researchers randomly assigned 171 patients with a range of back problems including herniated disks and spinal stenosis into two groups. One group saw an interactive video and received an educational booklet about surgery for their condition, the second group received the booklet alone.

Symptom and function outcomes at three months and 12 months were similar for the two groups, but the overall surgery rate was 22% lower in the video group. Patients with herniated disks in the video group who learned that their problem usually improves with nonsurgical care had a surgical rate of 32% compared to 47% for the booklet-only group.

Patients with spinal stenosis in the video group who learned their condition would probably stay the same for years without surgery had higher surgery rates than the booklet-only group — 39% compared to 29%.

The video had little effect on patient satisfaction, but patients in the video group felt better informed than patients in the booklet-only group, researchers note.

(See: Deyo RA, Cherkin DC, Weinstein J, et al. Involving patients in clinical decisions: Impact of an interactive video program on use of back surgery. Medical Care *2000; 38:959-969.)* ■

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. ■

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Nursing shortage	1	2	3	4	5
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