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

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HIPAA privacy regs to impact, alter CM responsibilities

Discharge planning likely to be significantly affected

Case managers struggling to determine what steps they must take to cope with the patient privacy regulations mandated by the Health Insurance Portability and Accountability Act (HIPAA) should bear in mind that privacy laws and guidelines have been around for some time. "We are living with privacy laws now," says health care attorney **James Pyles**, JD, a partner with Pyles, Powers, Sutter & Verville in Washington, DC. "These [HIPAA] regulations mainly try to codify the requirements that we have and, in some cases, increase the requirements."

Pyles argues that the final privacy regulations are actually better than they sound. "They are intimidating when we look at the bulk of them," he says. "But they largely codify what providers, physicians, hospitals, and home health agencies have been doing for years."

Mohit Ghose, senior vice president at the American Association of Health Plans in Washington, DC, says there are ways to make sure that patients are satisfied with the level of privacy they have in the health care system. "That is critical, because without a patient feeling secure that their information will not be sold to vendors or marketers, a strong doctor-patient relationship is impossible," he explains.

While the principle of protecting private medical information is critical, and the federal government is looking at alternatives that might better serve patients, hospitals, health plans, and physicians, Ghose says the way the law currently is written could seriously threaten the provision of health care.

One problem with the law is that only the minimum amount necessary of a patient's information can be transferred between physicians and hospitals. "What we are looking at is basically a

situation where some part of a medical history could be left out that could be very pertinent to ongoing treatment regimens," he explains.

To cope with the new requirements, **Heather Jahnke**, HIPAA project manager at General Health System in Baton Rouge, LA, says her organization has established an oversight committee with various operational teams; case managers will fall into the hospital operation team.

"Case management is not yet a core member of the team," she explains. "But as we address their issues, [case managers] will either be pulled into the team ad hoc or will meet with the team individually."

Jahnke says that General performed a two-level assessment. First, it created an internal assessment tool focusing on privacy, she reports. That tool comprised 102 questions and was administered to all team members, who meet twice a month.

General also distributed a smaller assessment with roughly a dozen questions that was distributed to every departmental manager in the hospital, including case management. That assessment asked about their use of disclosures and health information as well as a few security-related questions, such as whether they have processes for determining access, what information is stored, and how it is secured. The next step will be to prioritize what issues under privacy will be addressed first, she says.

"Much of what we will have to spell out under case management is going to be how much of what they do is considered treatment, because a lot of the discharge planning involves continued treatment," she says. The remainder of what case managers do is considered normal health care operations, and that requires making a determination about what information will require an authorization from the patient.

According to Jahnke, case managers will need a lot of extra consent in terms of internal planning and discussions with patients and designated family members. Some of the areas already have been broadly discussed. But General has yet to look at every process in case management, she says. From the perspective of an internal hospital case manager involved in discharge planning, there are still many questions about how payers will view the role of case managers.

Most payers consider it to be normal health care operations, Jahnke says. "I don't know how many patients are aware of the case management function within their insurance company. The question is, 'Do they really know that somebody is looking at all this information?'"

One of the issues General discussed from an organizational standpoint is what will happen when a physician calls to schedule a test or appointment.

"They should have consent to release that

More HIPAA action expected this year

The U.S. Department of Health and Human Services (HHS) will soon release changes to the privacy and transactions and code set rules of the Health Insurance Portability and Accountability Act, says **William Braithwaite**, senior advisor on health information policy in the department's office of the assistant secretary for planning.

Modifications to the rules will be in the form of a notice for proposed rulemaking publication, says Braithwaite, who spoke at the Toward an Electronic Patient Record 2001 Conference in Boston in May.

HHS expected to release guidance for the privacy rule in May in an attempt to clear up any discrepancies in the final rule.

Modifications to the rule, such as more clearly specifying when a patient's prior consent is needed to release his or her medical information, will be included in a notice for proposed rulemaking and released later this year, Braithwaite says.

HHS also expects to release a notice of changes for the transactions and code sets rule, including doing away with the National Drug Code code sets mandate, he adds. ■

information," she says. "But now we have that information, and even though we might not see the patient for two weeks, there are things we need to use that information for and disclose it for."

That means the hospital must check with the payer to determine if it gets the authorization or precertification, Jahnke says. It also means determining if the hospital can take information received by another source and then disclose it back to the payer without contacting the patient, she adds.

Unfortunately, the answers to these questions are not entirely evident, she says. Everybody is still waiting for the Department of Health and Human Services to release their documents clarifying these questions. "There are still a lot more questions than answers," Jahnke says.

According to Pyles, the privacy regulations are complex. On the other hand, they really only have four or five "moving parts," he explains. The regulations essentially do two things, says Pyles. First, they establish privacy standards and ways of exercising those standards. Second, they establish the process and procedures to access patient information. With respect to privacy, there are three basic protections or tools by which privacy will be protected — consent, authorization, and the opportunity to agree or reject.

"Consent is not new," asserts Pyles. "You have been getting consent for as long as you have been in this business or you should not be in it." But a hospital has to give patients notice that they are going to release some limited information, he adds.

Where authorization is concerned, it is critical to understand that when services are provided in a patient's home, there is a special duty to the patient, Pyles says. When patients enter a hospital, they understand and expect that they give up some of their rights to privacy, he argues.

When patients enter a nursing home, they give up some of their rights to privacy. However, when patients receive services in their homes, they want their privacy to remain intact if at all possible, he says. ■

Trauma center boosts patient outcomes

Good outcomes jump from 27% to 73%

Mission Hospital in Mission Viejo, CA, has improved its percentage of good patient outcomes for traumatic brain injury (TBI) patients from 27% in 1994 to 73% today. According to the Joint Commission on Accreditation of Healthcare Organizations, Mission Hospital's trauma mortality rate is 30% less than the national average. The hospital's trauma center attributes that success to a unique trauma nurse program that provides continuity of care during admission, diagnosis, and initial treatment.

The hospital's clinical outcomes for patients sustaining severe TBI from January 1994 to May 1997 were marginal at best, with 43% expiring and 30% suffering severe disability. In 1995, the American Association of Neurological Surgeons (AANS) published evidence-based clinical guidelines for managing TBI based on research that examined the outcomes of various treatment modalities.

In 1997, the trauma center seized on these recommendations, and a multidisciplinary trauma team initiated a performance improvement process that examined current practice and established new hospital-based clinical guidelines. "We asked our doctors and nurses to completely change the way they manage head injuries," says **Mary Kay Bader**, neuroclinical nurse specialist at Mission. She says Mission made "a total commitment" to bring its practices in line with those new guidelines.

According to Bader, that required extraordinary changes in the trauma center. "It requires a lot of education, bedside support, and mentoring," she explains. That included trauma surgeons, neurosurgeons, nurses, and others.

Those changes were motivated by the scientific guidelines published by the AANS, Bader says. "We took the entire booklet and implemented those scientific guidelines."

Notably, the guidelines were revised in 2000, and the authors revealed survey data showing that less than 20% of the country's trauma centers had fully adopted the guidelines, while another 40% had adopted only portions of them, she says.

Another key ingredient to success has been staffing patients according to their needs rather than just adhering to blanket policies, Bader explains.

"We are blessed that we have an administration that supports meeting the needs of the patient. It does cost more money to manage these patients, but our outcomes have been enhanced," she adds. "Instead of dying or going to a nursing home,

[patients] are going back to work and school."

Mission has a panel of neurologist and a neuroclinical nurse specialist who work with the emergency department team to manage stroke patients. Trauma center physicians have nearly 100 years combined experience, and each is board-certified.

The trauma center is certified by the American College of Surgeons (ACS), Committee on Trauma as a Level II trauma center. Notably, only 20% of the hospitals in the country have sought verification and received the designation since the ACS began the program in 1987. The center also has been accredited by the Orange County (CA) Emergency Medical Services Agency since 1980.

Mission employs state-of-the-art technology such as the spinal CT scanner and portable ultrasound, as well as the latest procedures and technology for the repair of vascular injuries and advanced techniques in the care of severe respiratory conditions.

"I think every hospital in the country has a CT scanner," says Bader. On the other hand, there are still trauma centers that treat head injury patients without putting a pressure monitor in the patient's brain even though that technology has been available for years. "It is a $100 piece of equipment," she says. "But some neurosurgeons and trauma centers refuse to change their practice.

According to Bader, Mission's in-house acute rehabilitative unit ensures continuity of care. An interdisciplinary team meets weekly to discuss patient needs, including metabolic requirements, rehabilitative needs, social service, and discharge needs. "Our team incorporates not only the intensive care phase but the surgical and rehab units," she says.

Occupational and physical therapists are involved in the patient's treatment from the outset. "They become aware of the patient's needs early on, and that provides continuity," says Bader. Specially trained nurses who have completed the Advanced Trauma Care for Nursing program are based in Mission's trauma/neuro intensive care unit (ICU).

When emergency surgery is required, a trauma nurse stays with the patient and monitors all physiologic needs as well as communications with family members. According to Bader, those nurses meet the patient as well as the family at the outset. She says that helps facilitate the patient's transition from the ICU to the surgical unit and the rehab unit.

"There is a very smooth transition," says Bader. "I think that makes a big difference." In addition, 24-hour pastoral care provides support for family members throughout the patient's stay.

Mission is one of only three designated trauma centers in all of Orange County. As the largest medical center in south Orange County, the trauma center treats nearly 700 traumas each year.

Mission's work in this area has been acknowledged by the American Association of Critical Care Nurses (AACN) in Aliso Viejo, CA, which recently awarded Mission Hospital with the prestigious AACN Mutidisciplinary Team Award. In 1994, the hospital became one of 14 Catholic, not-for-profit hospitals operated by the St. Joseph Health System and sponsored by the Sisters of St. Joseph of Orange. Last year, the Trauma Center was awarded the coveted Codman Award from the Joint Commission. ■

Case managers improve physician involvement

Physician 'socialization' must be overcome

Case managers must confront the fact that, in general, physicians have an innate cultural conflict with the health care system where it involves nonphysicians, says **Lynne Nemeth**, RN, MS, director of outcomes management, research, and development at the Medical University of South Carolina in Charleston. To address that problem, she says, case managers must employ an array of tools and tactics to gain the support of physicians.

The conflict is based on physician training and socialization, Nemeth explains. The result is that physicians often are not aligned with case managers and have a different focus on the patient and a different time frame for action as well as a different view of resources.

According to Nemeth, there are numerous tools that case managers can use to gain the attention of physicians. For example, she says, physicians rely heavily on their experience from their last patient as well as local guidelines, pathways, and continuing medical education (CME).

Other factors that influence physicians include governmental oversight, accrediting bodies, journals, colleagues, training, informatics, and incentives. "Those are just some of the many ways to

grab their attention," she says.

Relationships are very important, too, Nemeth says. That can include informal power politics, coalition building, and influence.

Francie Handler, RN, BSN, CMC, team supervisor in case management at St. Vincent's Hospital in Sante Fe, NM, takes a similar view. "Doctors listen to doctors."

In the case of St. Vincent's, Handler says, they also listen to the chief medical officer, whose role she credits with significant enhancements in case management programs.

"If we are unsuccessful in getting the doctor on board from the case management perspective, our medical director is very helpful," she says. When those interventions take place, the chief medical officer uses very specific information and makes sure there is an identifiable problem to be addressed.

Numerous approaches can be used to alter physician behavior, such as physician education, employing opinion leaders, and getting involved with academic detailing, as well as audit and feedback, clinical decision support, and physician incentives, Nemeth says. In addition, case management, critical pathway teams, and any other team-driven approaches to the processes of care in decreasing variation also can play a role.

The increase in direct-to-consumer advertising by the pharmaceutical industry presents another approach that alters physician behavior, she says. There is a growing sentiment that marketing to physicians should be explored. "It is almost like market research to better understand how to motivate physicians," she says.

CME may provide information, but it does not necessarily change a practice, according to Nemeth. On the other hand, there is some evidence from the literature that it is productive to spend time doing academic detailing.

Nemeth notes that providing feedback from different projects, such as benchmarking projects and the Health Plan Employer Data Information Set, also are very important. But the effect of providing statistically significant information often can be small to moderate. "We should not rely solely on that approach," she says. "Even though data may be well-developed, they are not necessarily going to impact [physicians'] behavior."

What really needs to be established is real-time feedback, including reminder systems that are built into physicians' process of care such as computerized order entry, Nemeth says. "You need to build in ways to get the feedback to them at the point of care rather than after the fact so they have to think about it the next time. Reminders have good potential if they are built in in real time."

Handler takes a similar approach. She and her staff employ simple tactics such as leaving easily identifiable notes on the front of the chart. For example, on the orthopedic floor, prescriptions are left for medical equipment, home care, and pharmaceuticals just to ensure doctors don't forget anything. Doctors then can complete and sign the items they deem appropriate. That creates more work on the front end but saves a lot of time on the back end, she says.

Engage your physicians with technology

Economic incentives are the most specific motivator, Nemeth says, but financial incentives are not always legal and must be matched with the structure of the support system. For example, if physicians can get the state-of-the-art equipment they require for surgical procedures and similar improvements, that can be a motivating factor. "You have to match the incentive to the resources they are asking for," she says.

Collaborative pathways and other case management systems and interventions that are designed to support the patient are all very important, says Nemeth. But in order to get physicians on board to collaborate, doctors must have their own self-interest to engage in the activity.

The hospital's imperative is to identify how physicians can benefit, and that often involves technology. That might take the form of a new MRI or a microscope in the operating room that allows a surgeon to act with more precision. Such equipment ultimately will reward physicians financially because they have a higher caseload and more patients, she explains.

In short, when a hospital provides physicians with the tools, equipment, and resources they require, whether in material resources or human resources, Nemeth says, "The system recognizes the value physicians bring to playing the game of health care improvement."

Finally, in order to improve patient outcomes, case managers must provide performance data in an informative manner rather than a punitive manner, she says. That means looking at the full range of outcomes, patient and provider satisfaction indicators, clinical outcomes of strategic importance, and cost and resource utilization.

This range of tools gives a good sense of balanced indicators that do not approach it solely from the financial point of view.

"The financial point of view alone is not going to motivate physicians," Nemeth says. "They want to provide the highest quality care." ■

APCs and observation: Learn when to admit

Consulting and educating physicians is key

(The following is excerpted from "Reimbursement: An ever-changing process," given by ***Deborah Hale****, CCS, at the sixth Annual* Hospital Case Management *Conference in Orlando, FL, March 26. Hale is president of Administrative Consulting Service Inc. in Shawnee, OK.)*

Certain implants and devices; the anesthesia; the recovery room — all are packaged services. One which has become the most catastrophic for most hospitals is observation following an ambulatory surgery procedure, or with a medical observation patient who presented to the emergency department (ED).

Here's an example of a patient who came into the ED:

The patient, who had no previous history of coronary artery disease, came in with chest pain and nausea. The EKG was normal, the enzymes were negative, and the lungs were clear, but nevertheless, the ED physician felt it was important to keep the patient for observation, to get some additional lab work back, and to make sure that an acute myocardial infarction was not occurring.

The patient receives IV morphine for control of the pain, and so we're reimbursed for an IV injection. That ambulatory payment classification (APC) is a status X, which is an ancillary service APC, and generates a payment of $47. An EKG generates an APC payment of $18. Of that, the patient pays $16 and Medicare pays $2.

The chest X-ray will generate an APC payment, and all of the ancillary services will be paid by an APC, if medical necessity for the services is documented and coded.

Now, in managing this patient in the ED, we're going to use med/surg supplies, and we're going to administer some routine pharmaceuticals. Morphine is not considered a routine pharmaceutical, so that actually generates a separate payment. But any other drugs that we give to the patient — unless it's a thrombolytic drug or some of the other high-cost drugs in the ED — would be packaged under routine pharmacy.

The real kicker: We keep this patient in the intensive care unit (ICU) for observation, and there are zero dollars assigned there. The Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration) consider that when we assigned this case to a high-level ED visit, that payment rate of $158 was supposed to cover all of our observation time. Obviously, it's not going to do that when the patient's in ICU for observation. As a result, we've had some real trouble with hospitals trying to decide, "Is this an appropriate patient to admit to observation status, or is this an appropriate inpatient admission?"

With the services delivered as I've listed above, our total APC payment is $263 for this patient, who may have stayed 24 or 36 hours. We can't stay in business very long with those kinds of reimbursement amounts. Now, in addition, any lab tests that the patient has are paid by the fee schedule, so the total amount is $263, plus those individual lab tests, subject to documentation of medical necessity.

In the APC final rule (published April 7, 2000), CMS says, "We believe that, in general, if a patient needs to be monitored in the ICU or the CCU [critical care unit] for any length of time, then the patient should be admitted as an inpatient." So right there is the answer to your overutilization of observation and the fact that you're not getting paid for ICU and CCU observation under APCs. CMS has told you: "Admit those patients if they need to go to ICU or CCU."

From a financial perspective, had we left our patient in observation status, our total APC reimbursement would have been less than $300. That would allow a little extra for some lab tests that were done. But if we convert the patient to an inpatient admission, the DRG payment would be dependent upon what caused the patient's chest pain. If the physician says, "I can't prove it, but I think this is cardiac, and so we're going to schedule him later for a cardiac cath," then suspect angina would drive the DRG assignment, and that's a $3,000 payment.

So many times, what we see is that, after study,

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CRITICAL PATH NETWORK™

Cutting the cost of observation: Create a 'hybrid unit'

If you want to keep your observation unit open, you'll need to look at new strategies, explains **Patricia Hall**, RN, MSN, CEN, service leader for emergency services at Howard Young Health Care in Woodruff, WI. "The advent of APCs [ambulatory payment classifications] has made it difficult for observation units to be financially sound," she adds.

Although there is not currently a separate APC for observation, the Baltimore-based Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration, is expected to add a separate APC this year *(For more details, go to the Society of Chest Pain Centers and Providers web site: www.scpcp.org, and click on "HCFA discussion on observation services.")* Taking these steps can help cut your unit's costs:

• **Create a "hybrid" unit.** The observation unit at William Beaumont Hospital in Royal Oak, MI, began as a hybrid "observation/scheduled-procedure" unit, says **Michael A. Ross**, MD, FACEP, director of the emergency observation unit and chest pain center. There was a problem with low census in the afternoon, he explains. "We would drop down to one or two patients, which is prohibitive from a nursing staffing standpoint." The eight-bed unit was separate from the emergency department (ED), so it wasn't possible to decrease the nursing staff to a single nurse, adds Ross.

The solution was to allocate a set number of beds for observation patients and for scheduled-procedure patients. "Combining these two services enabled us to always have enough patients and maximize the use of that space," says Ross. As the observation service grew to 21 beds, the ED was able to maintain an adequate census of observation patients. "We found we no longer needed to be a hybrid unit. Over time, we weaned out the scheduled-procedure patients. We identified an inpatient location that could accommodate those patients and displaced them to that setting."

• **Address staffing issues.** Initially, the observation unit at William Beaumont had an all-nursing staff doing primary care with a case ratio of one nurse per four patients, says **Pat Zientek**, RN, the emergency center's administrative nurse manager. But the current ratio is one nurse per five patients. "Increasing the ratio was important to decrease costs," she notes. "Two less-costly technicians were introduced per shift who were cross-trained for the unit secretary duties." The hybrid model allows you to staff with an average hourly patient/nurse ratio of 3.7 compared with the ratio of 2.5 for a regular observation unit, says Ross. "This reduces the cost by 0.13 nurse full-time equivalent per patient."[1]

• **Avoid prolonged observation.** Patients who "succeed" in observation will be discharged long before 24 hours, says Ross. "The concept of a 24-hour observation unit is antiquated," he argues. "Most patients define themselves by 18 hours. If they cannot go home by then, they have a very high probability of needing hospitalization." The ED observation unit requires that a disposition be made in 18 hours, unless the physician documents a clear and compelling reason to continue observing the patient, says Ross. **(See Physicians Order Sheet - EC Observation Unit, Observation Unit Chest Pain Tracking Sheet, and Patient Observation Record, pp. 120-122.)**

• **Only observe appropriate patients.** At Howard Young Health Care, the ED has become more selective with the patients placed on observation status, notes Hall. "If their condition appears

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Beaumont
William Beaumont Hospital

INJECTION SITE CODES

A - LEFT DORSOGLUTEAL	B - RIGHT DORSOGLUTEAL
C - LEFT VENTROGLUTEAL	D - RIGHT VENTROGLUTEAL
E - LEFT THIGH	F - RIGHT THIGH
G - LEFT ARM	H - RIGHT ARM
I - LEFT ABDOMEN	J - RIGHT ABDOMEN

PHYSICIANS ORDER SHEET - EC OBSERVATION UNIT

ATTENTION PHYSICIAN: This preprinted form is available to facilitate patient care.
Order items by checking the box in front of the item and / or completing the blanks where necessary.
If additional items are needed, add them on the standard Doctors Order sheet (Form 280).

REASON FOR OBSERVATION : / EC OBSERVATION PLAN OF CARE

1. Initial Obs Unit ECP : Time Contacted :
2. Private Physician : Time Contacted :
3. • Print ECP Dictation ASAP
4. Allergies:
5. • Vital Signs per Routine
6. Activity : ☐ BRP ☐ Other _____
7. Respiratory : ☐ O2 per guidelines
8. Diet : ☐ Regular ☐ Cardiac ☐ _____ cal ADA
   ☐ _____gm NA ☐ _____ liquid
9. TMS : ☐ NO ☐ YES (Patients on TMS may be transported to EC Obs unit without an RN)
10. ☐ Home medications - transcribe onto med sheet. ECP to review and order
11. CPR Status Order : ☐ Full CPR (Call CPR Team)
    ☐ No CPR (CPR team will not be called, no chest compressions will be initiated by unit staff in the event of cardiopulmonary arrest)

_____ Page No. _____
Attending Physician Signature

MEDICATION ORDERS AND ADMINISTRATION RECORD

	Date	Date
12. ☐ IV 0.9NS @ _____ ml/hr OR	0000 1200	0000 1200
☐ Heparin Lock	0000 1200	0000 1200
13. ☐ Prochlorperazine (Compazine) 5 mg IV Push Q 6h PRN nausea OR	0000 1200	0000 1200
☐ Trimethobenzamide (Tigan) 200 mg IM Q 6h PRN nausea	0000 1200	0000 1200
14. ☐ Acetaminophen (Tylenol) 975 mg PO Q 6h PRN pain or fever (maximum 4gm/24hrs)	0000 1200	0000 1200
15. ☐ Ibuprofen (Motrin) 600 mg PO Q 6h PRN pain or fever	0000 1200	0000 1200
16. ☐ Maalox 30cc PO PRN indigestion	0000 1200	0000 1200
17. ☐ Temazepam (Restoril)15 mg PO QHS PRN sleep	0000 1200	0000 1200

Sending ECP Signature	Dr. Page No.	Date	Time	Name & ID #	Name & ID #

Noted by Unit Secretary	Date	Time	Noted by R.N.	Date	Time		

7679A FEB 99 WP Medical Record

Beaumont
William Beaumont Hospital

PATIENT ID STAMP

EC OBSERVATION UNIT CHEST PAIN TRACKING SHEET

	Time 0 = triage time (ECG, CKMB, Myo)*	4 hours (ECG, CKMB, Myo)	4hr – 0hr ** CKMB / Myo diff.	8 hours – *if needed* (CK, TnT, ECG)***
Time				
ECG				
CK (M<230, F<150)				
CK-MB (< 10ng/ml)				
CK-MB index (< 4.0%)				
Myoglobin (< 110ng/ml)				
Troponin T (<0.2ng/ml)				

*** If** 4 hour labs are sent, **call lab** to add Myoglobin to initial EC blood.
******4hr – 0hr diff. = Myoglobin and CKMB change over 4 hours = Time 0 hr (EC) – 4 hr level
******* 8 hour testing indicated if: **(a) 4 hr test missed, (b) any Myoglobin elevated, (c) Myoglobin or CKMB are NORMAL but DOUBLES over 4 hours.**

4 HOUR ECG: _____

Stress test (circle one): TIME DONE _____

GXT / GXT-MPI / PERSANTINE / GXT-Echo / Dobut.-Echo / NONE

Stress test results (circle one):

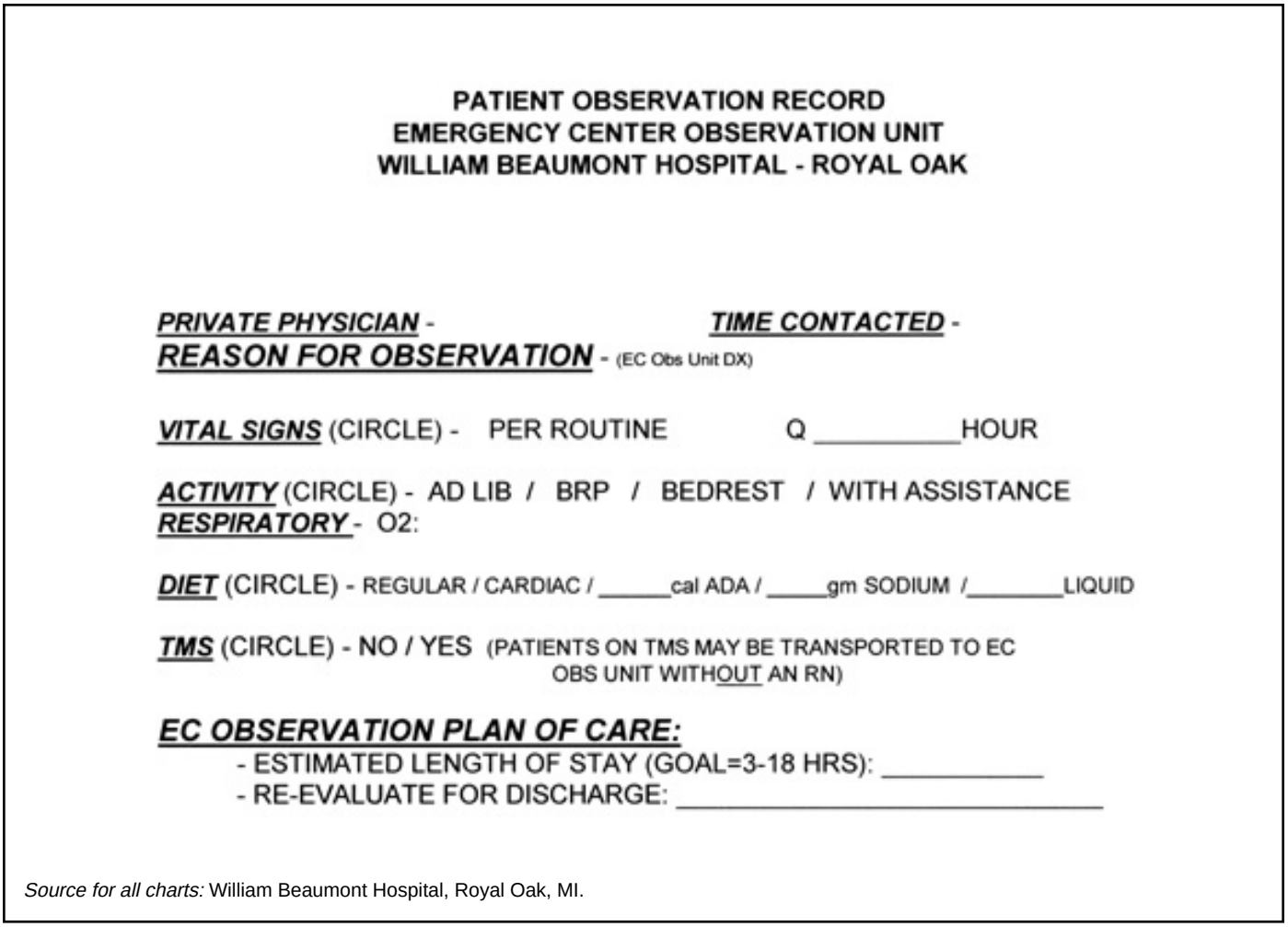
NORMAL / ABNORMAL / EQUIVOCAL - INDETERMINANT

FINAL Observation Unit diagnosis (circle one):

- MI
- Unstable angina
- Musculoskeletal chest pain
- Gastritis – esophagitis
- Anxiety disorder
- Other (write in) _____

NOT A PERMANENT PART OF THE MEDICAL RECORD

7680 X MAY 99



PATIENT OBSERVATION RECORD
EMERGENCY CENTER OBSERVATION UNIT
WILLIAM BEAUMONT HOSPITAL - ROYAL OAK

PRIVATE PHYSICIAN - ***TIME CONTACTED*** -
REASON FOR OBSERVATION - (EC Obs Unit DX)

VITAL SIGNS (CIRCLE) - PER ROUTINE Q _____HOUR

ACTIVITY (CIRCLE) - AD LIB / BRP / BEDREST / WITH ASSISTANCE
RESPIRATORY - O2:

DIET (CIRCLE) - REGULAR / CARDIAC / _____cal ADA / _____gm SODIUM /_____LIQUID

TMS (CIRCLE) - NO / YES (PATIENTS ON TMS MAY BE TRANSPORTED TO EC OBS UNIT WITHOUT AN RN)

EC OBSERVATION PLAN OF CARE:
- ESTIMATED LENGTH OF STAY (GOAL=3-18 HRS): _____
- RE-EVALUATE FOR DISCHARGE: _____

Source for all charts: William Beaumont Hospital, Royal Oak, MI.

(Continued from page 119)

to be more complicated with potential comorbidities, we are opting for admission. This seems to be exactly contrary to how we used to think. But honestly, they traditionally have ended up staying more than 23 hours anyway."

At William Beaumont's ED, only specific conditions can be sent to the unit, based on specific inclusion / exclusion criteria. "The physician or nurse covering the unit is empowered to refuse a patient based on failure to meet these criteria," says Ross. **(See "Which Patients to Observe," p. 125.)** The ED uses written guidelines for 32 conditions, along with general principles on which patients are appropriate for observation, says Ross. "You must be managing only one specific acute problem, and it must be a problem of limited severity of illness that has a 70% to 80% probability of being discharged within 18 hours." The guidelines are converted into orders specific for 80% of the conditions sent to the unit. "This helps to maintain consistency," he says.

• **Offer stress testing in close proximity.** Previously, 25% of the patient volume was transported to the eighth floor for stress testing, which necessitated a 15-minute trip each way of "nonproductive time," says Zientek. "To decrease the time off the unit, we have installed a stress lab directly adjacent to the unit, with a one- or two-minute trip each way."

The satellite stress-testing lab reduced the length of stay of chest pain patients by a couple of hours, says Ross. "This allows the hospital to do stress testing on weekends for chest pain patients and get inpatients out sooner."

[For more information, contact:

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Reference

1. Ross MA, Naylor S, Compton S, et al. Maximizing use of the emergency department observation unit: A novel hybrid design. *Ann Emerg Med* 2001; 37:267-274. ■

PATIENT EDUCATION
QUARTERLY

These aren't your usual patient ed committees

Is your patient and family education committee being put to good use? There's no need to limit committee members to serving as gatekeepers or a review board for written brochures or educational resources. Patient education committees can improve patient education in many innovative ways.

"An interdisciplinary committee can best identify barriers to education, propose and test solutions, and implement changes in the system. They share information with and collect feedback from the whole organization. No one person, or one department, can accomplish what representatives from the entire system can do," says **Fran London**, RN, MS, health education specialist at The Emily Center at Phoenix Children's Hospital and a member of the hospital's patient/family education council.

Patient education committees can provide a broad view, and those disciplines involved will help keep the importance of education at the forefront in their patient care area. When you have more people incorporated, it isn't some isolated manager in an office trying to touch every base and connect with every person, says **Linda Kocent**, RN, MSN, coordinator of patient-family education at The Children's Hospital of Philadelphia.

Committees keep the work manageable as well, she says. At The Children's Hospital of Philadelphia, there are 12 decentralized, specialty-based committees that work in specific areas and a patient education steering committee that provides oversight and guidance as well as institutionwide directives. The steering committee consists of a leadership person from each discipline and the chair of each decentralized committee. Kocent sits on all 13 committees.

"I make sure that each knows what others are doing as needed, and prevent duplication of efforts. I help them see that patient and family education is more than writing handouts, and help them 'think outside the box.' It is incredibly time-consuming, but worth it in results."

Each year, the decentralized committees identify needs and set goals to present to the steering committee and report on prior work. "The specialty-based committees usually come up with ideas based upon a need they identify within their group," says Kocent. For example, a teaching need might be identified within an area so the committee will initiate the writing of new curriculum for a class taught at the learning center. A clinical expert, usually an advance practice nurse, will be selected by the committee to write the curriculum and work with learning center staff to ensure that they are competent to teach the content.

Every group identifies projects pertinent to their area. Currently, the pediatric intensive care unit (PICU) committee is developing a photo book to use with siblings of patients prior to their visit to the PICU as part of the Child Life visitation program. When it became apparent that families no longer had time to bring their children to the hospital for pre-surgery tours, the surgery committee created a virtual pre-op surgery tour that parents and children can access via the Internet at home. If one of the specialty committees determines that something electronic would enhance patient education, they invite the health care institution's web team to a committee meeting, and the team helps them work through the process.

To promote family literacy, the primary care committee developed posters with tear-off slips that connect families to the mayor's commission on literacy for free reading classes. The committee also is beginning to work on children's books on health care to support the literacy campaign. The books will be written very simply so that low-literacy adults can read to their children, thus improving their skills and reinforcing the importance of reading in the eyes of their children.

There are certain patient education issues that pertain to all specialty areas such as measuring outcomes or compliance with the patient education standards set by the Joint Commission on

Accreditation of Healthcare Organization (JCAHO). In these cases, all committees design projects pertaining to their specialty. For example, for measuring outcomes, the cardiac services committee is looking at whether the learning needs of cardiac surgery patients are met before they are discharged from the cardiac intensive care unit instead of the step-down unit. To meet JCAHO standards this year, all committees are looking at how to incorporate pain as the fifth vital sign in their area and document it, says Kocent.

While Phoenix Children's Hospital has only one committee with 15 interdisciplinary members, it serves as a patient education committee, JCAHO oversight committee, and quality improvement team for process improvement initiatives relating to patient and family education. "The work of all three functions overlap, and we usually address them all at each meeting," says London. The three functions include:

• **Patient/family education.** The group coordinates patient and family education activities throughout the organization. The most extensive project in this category has been the revision of the interdisciplinary education record, which took two years to complete. To create a form that staff would use, committee members surveyed all those who document patient education, such as nurses and social workers.

• **Joint Commission oversight.** In this category, committee members conduct chart reviews to assess patient education compliance with JCAHO standards, identify what improvements need to be made, implement them, and prepare for JCAHO visits. As part of the preparation, the committee plans staff education activities to address problems.

• **Quality improvement team.** This team's mission is to improve patient and family satisfaction scores relating to education. To achieve this goal, it has looked for root causes for problems relating to patient and family education, examined possible interventions, and proposed the hiring of a patient education coordinator and assistant to implement the committee's proposals.

The positions for coordinator and assistant were piloted and made permanent. Improvements have included a distribution system for teaching materials, and a partnership with the nursing education department to facilitate staff education on patient and family education skills. ■

Switching gears to improve patient education

Sometimes, patient education committees don't always end up where they started out.

The patient education committee at Shands at the University of Florida in Gainesville was originally implemented in 1996 to help the institution meet Joint Commission on the Accreditation of Healthcare Organizations' standards for patient and family education, but now its tasks evolve according to the organization's needs. For example, a couple of years after its founding, a patient satisfaction survey revealed a need for quality improvement in education. The administration asked the committee to focus on continuous quality improvement (CQI), so it became a CQI team, says **Kathy Gamble**, ARNP, MN, coordinated care manager in the department of nursing and patient services and co-chair of the committee.

The committee, made up of 30 people representing the various services and departments throughout the health care system, came up with five overall recommendations. They included:

• Establish patient and family education as a priority across Shands health care.

• Create an ongoing multidisciplinary team for patient and family education.

• Develop a computerized systemwide index of materials available including samples of materials.

• Provide consistent admission information to patients and families.

• Develop a coordinated team approach to ensure an interdisciplinary treatment plan.

To get work done efficiently, the committee prioritized tasks, first creating the ongoing multidisciplinary team for patient and family education by solidifying the committee. Their second project was to create a computerized systemwide index of patient education materials.

Because there is no one who coordinates patient and family education and the committee members have many other duties, the patient education committee at Shands is a working committee. "We decided that our meetings would be working meetings, and we would more or less do the work we needed to do within the meetings," says Gamble. When legwork is required, such as the cataloging of patient education materials, health education interns from the university are used.

Some of the other quality improvement tasks the committee has completed include patient and family education as part of employee orientation and a policy to ensure consistency in the quality of internally developed materials. ■

Which Patients to Observe

INDICATIONS FOR OBSERVATION

✔ **Focused goal of patient care.** The physician's notes should document the reason for observation. Generally, there should be only one specific problem that requires acute management. When multiple problems require management, the likelihood of admission is much higher. The three broad categories of observation are:

- **diagnostic evaluation of a critical syndrome**, such as chest pain, abdominal pain, etc.;
- **short-term treatment of emergency condition**, such as dehydration, asthma, renal colic, etc.;
- **management of psychosocial needs**, such as psychiatric, social worker, or continuing-care evaluation and management of selected problems.

✔ **Limited intensity of service.** This is judged clinically by the emergency center (EC) physician. Patients not meeting this criterion should be managed in the EC or admitted to the hospital (i.e., patients who require one-on-one nursing care).

✔ **Limited severity of illness.** This also is judged clinically by the EC physician (i.e., patients who are in extreme conditions or clinically unstable). Following low severity of illness/intensity of service (SI/IS) criteria enables the observation unit to be run effectively.

✔ **Clinical condition appropriate for observation.** In general, the observed condition should have a high (70% to 80%) probability of discharge within 18 hours. It should also be a condition for which initial discharge from the EC is not likely (i.e., an otherwise admitted condition). In addition to the list of "Observation Unit Clinical Conditions" included in this packet, the physician covering the unit may elect to observe other conditions if they meet the above criteria. This group will be monitored.

CONTRAINDICATIONS TO OBSERVATION

✔ **High severity of illness.** Patients requiring more nursing care than can be offered in the unit. For example, patients with unstable vital signs, or unstable cardiac, pulmonary, or neurological condition. These patients should be managed in the initial EC treatment area until deemed to be stable for at least one hour.

✔ **High intensity of service.** Patients who are too unstable or ill to be observed. For example, difficult intoxicated or suicidal psychiatric patients, patients requiring frequent vital signs or treatments.

✔ **Patients requiring admission.** If inpatient admission is apparent in the initial treatment area, the patient should not enter for "observation." This type of patient is defined as a "hold" if they are simply waiting for a bed.

✔ **Age less than 13 years old.** These patients will be managed on the inpatient pediatric floor. Pediatric patients over the age of 13 who are transferred to the observation unit should not have significant underlying illness or comorbidities, which may require increased nursing care (high SI criteria).

✔ **Obstetric patients more than 20 weeks pregnant.** These patients should be managed on the Labor and Delivery (L&D) unit according to EC policy. If they have already been evaluated on L&D and sent back to EC, or cleared by their private obstetrician for management of a non-obstetrical condition (i.e., asthma), they may be managed in the observation unit.

✔ **Anticipated observation length of stay less than three hours or more than 18 hours.** The work of transferring, admitting, and discharging the patient is not efficiently spent if the patient stays for less than three hours. A regular audit of such admissions will be performed. Since most observed cases are discharged in 10 to 15 hours, cases that will clearly require more than 18 hours of care are unlikely to benefit from the unit.

✔ **Nursing home placement.** Patients must first have the feasibility of their observation placement plan approved by the continuing care or admissions transfer office nurse. This group often fails placement in a timely manner.

Source: Emergency Center Observation Unit Guidelines, William Beaumont Hospital, Royal Oak, MI.

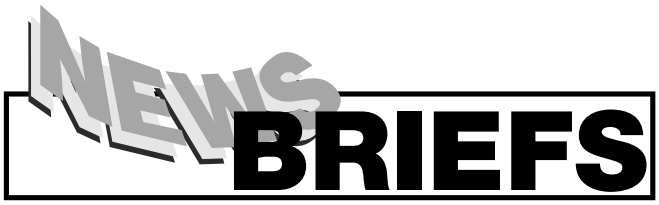
(Continued from page 118)

physicians decide that this is reflux disease. That pays even better. You have to know the insides of the system to be paid, and to understand what does help us. So often, the physicians will just say "noncardiac chest pain," but if you look at the home meds — what they're sending patients home on — and that physicians have documented the reflux disease, getting that additional documentation would drive the payment up to $3500. And, if in fact, we hold them to a cardiac cath during this admission, and it turns out that they have coronary artery disease, the DRG payment for that is $6,300. So a lot of money can slip through our fingers if we overutilize observation status under APCs.

I have seen letters from CEOs advising their medical staff that they no longer have observation

services. I would encourage you not to do that. Observation still does exist. And there are still times when it is appropriate to use an observation bed rather than formally admitting that patient as an inpatient. **(For guidelines, see box, p. 125.)**

Outpatient prospective payment seeks to put up a huge wall to divide outpatient services from inpatient services. We have to recognize that wall and know where it is if we're going to be successful financially in managing our patients. ■



HHS task force will target patient safety

Department of Health and Human Services (HHS) Secretary **Tommy Thompson** has announced that a new Patient Safety Task Force has been established within HHS that will coordinate a joint effort among several agencies to improve existing systems to collect data on patient safety.

These agencies include the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, the Food and Drug Administration, and the Centers for Medi-care and Medicaid Services (formerly the Health Care Financing Administration). HHS' fiscal 2002 budget proposal includes up $72 million, an increase of $15 million over fiscal year 2001, for efforts to improve patient safety and reduce the number of adverse events.

In addition, Thompson has charged the task force with studying how to implement a user-friendly Internet-based patient safety reporting format. The group will develop computer networks, user-friendly reporting systems, and standards for coding the content of the reports, reports *AHA News*. The system will feature a uniform data collection method. The Centers for Disease Control and Prevention and the Food and Drug Administration will provide data on medical errors, while the Agency for Healthcare Research and Quality will analyze the causes of medical errors. ▼

5. The internal privacy assessment tool created at General Health System in Baton Rouge, LA, is comprised of how many questions?
   A. 12
   B. 102
   C. 52
   D. 92

6. According to year 2000 data from the American Association of Neurological Surgeons (AANS), what percentage of U.S. trauma centers have fully adopted the 1995 AANS guidelines for managing traumatic brain injury?
   A. 20%
   B. 27%
   C. 30%
   D. 73%

7. Which of the following tactics can be effective in improving physician involvement in case management and quality efforts?
   A. getting intervention/support from the facility's chief medical officer
   B. providing physicians with informative performance data
   C. creating legal financial incentives
   D. all of the above

8. An EKG generates an APC payment of $18. Of that, how much must the patient pay?
   A. $2
   B. $8
   C. $16
   D. $18

CMS proposes increase in rates for hospitals

Hospitals across the United States would see a 2.55% increase in Medicare payment rates in fiscal year 2002, according to a proposed rule issued by the Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration) in Baltimore and published in the May 4 *Federal Register*. The proposed increase, which would become effective Oct. 1, 2001, will affect about 4,800 acute care hospitals that are paid under the prospective payment system (PPS). The proposed rule also contains provisions to implement a number of mandates in the Medicare, Medicaid, and State Children's Health Insurance

Program Benefits Improvement and Protection Act of 2000, which will also become effective Oct. 1, 2001. Among these is a proposed mechanism to facilitate access to high-cost new services and technologies by authorizing special payments to cover increased costs.

The proposed rule also makes a number of revisions to DRG classifications. For example, the proposed rule would create two new pancreas transplant DRGs and would create new DRGs for cardiac defibrillator cases and percutaneous transluminal coronary angioplasty cases.

In addition, the proposed rule provides for a three-year hospital geographic wage index reclassification, the use of three-year averages of the average hourly wages in qualifying for geographic reclassification, and the option to use a statewide index instead of individual wage indexes for the geographic area of a state. CMS plans to publish a final inpatient PPS rule by Aug. 1, for implementation Oct. 1, 2001. ▼

Hospital to study effect of electronic records

The University of Colorado Hospital in Denver has announced two new grants for controlled studies of how patient care is affected by electronic access to medical records.

The announcement of The Commonwealth Fund gift of more than $282,000 plus a significant

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Editorial Questions

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

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grant from CaP CURE was made at a University of Colorado Hospital Authority Board of Directors meeting by **Dennis Brimhall**, president and CEO.

With support from the Commonwealth Fund grant, researchers Steve Ross, MD, and C.T. Lin, MD, will manage a study of the effect of patient access to electronic medical records (EMRs) on the attitudes, expectations, and experiences of patients and physicians at a specialty clinic for heart failure at the hospital.

Researchers will conduct a controlled study of patients with congestive heart failure who are provided access to their EMRs via the Internet and will evaluate the effect of EMR availability on patients' understanding of their conditions, their ability to provide self-care, and their confidence in the care they are receiving. Physicians' views on medical record access also will be studied.

The grant from CaP CURE will help fund a study of about 30 prostate cancer support group members to determine how their use of the Internet affects their medical care.

The grant will help patients communicate directly with their physicians at any time via the Internet. Michael Glode, MD, will direct that study. ▼

Hospital profit margins show negligible increase

Operating profit margins at U.S. hospitals flattened at an annualized average of 3.69% in 2000, indicating only a slim degree of financial health, according to a report by Solucient, a provider of benchmark information on health care.

Hospital operating margins increased 0.41% over 1999 and remained relatively low, a full 36.6% lower than in 1997. Solucient president **Gregg Bennett** says margins of from 3% to 4% are not sustainable in the long run, especially given the pressure from increasing drug costs and hospital labor shortages.

He also says hospitals are still feeling the sting of the 1997 Balanced Budget Act and its clamp on Medicare payments.

Other key findings from the study, "The Health of Our Nation's Hospitals," include: Smaller hospitals finished the year best at 4.84%, their highest operating margin since 1997; larger hospitals produced the slimmest operating margins at 2.83%; regionally, western hospitals posted the weakest operating margins — 3.9%, while northeastern hospitals fared the best, going from break-even in 1999 to almost 5% in 2000. For more information, visit www.solucient.com. ■

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. ■