AMERICAN HEALTH CONSULTANTS

HOSPITAL CASE MANAGEMENT™

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

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Tight economy swells demand for case management certification

Do you know which credential is right for you?

The field of case management has yielded a variety of credentialing opportunities that provide a daunting landscape for case managers seeking certification. Several industry veterans say the increasingly competitive job market makes those decisions more important then ever.

According to **Lori Heiser**, LSW, CMC, case manager at St. Joseph's Hospital and Health Center in Dickinson, ND, the question of which certification carries the most benefit has been relevant for some time. But she says there is no clear evidence to answer that question.

There are myriad certifications, and some are more credible then others depending on how they are developed and maintained, says **Janet Maronde**, RN, executive director of the Healthcare Quality Certification Board (HQCB) in San Gabriel, CA, which administers the Certified Professional in Healthcare Quality (CPHQ) credential.

It is difficult to stay abreast of the core body of knowledge of all the various programs, she adds. "I am in the business, and I would not even profess to be familiar with all of the certifications that are out there," Maronde says.

"Case management is still being pioneered, and it is difficult to say that what works for one facility will work for another," Heiser points out. The options are so numerous that even determining what criteria to look for in assessing different credentialing agencies is a difficult task, she says.

According to **Susan Gilpin**, chief executive officer of the Commission for Case Manager Certification (CCMC) in Rolling Meadows, IL, which has certified more than 22,000 case managers,

CCMC is seeking to remedy that concern.

Hospital case managers typically are concerned about the eligibility criteria, and some of those issues currently are under review by the CCMC, Gilpin says. The primary issue has been an eligibility requirement, which states that case managers should provide services "across the continuum of care in multiple environments," she says.

"The debate has been whether . . . the services hospital case managers provide extend across the continuum of care and outside the walls of the hospital," Gilpin explains. "That has probably been the biggest stumbling block for hospital case managers as the commission has worked to interpret and apply the eligibility criteria to this practice setting."

Specifically, Gilpin reports that the CCMC has established the Certification Eligibility Review Task Force to assess the interpretation and application of the definition of "the continuum of care" through research that includes a survey of practitioners. The eligibility criteria may not be changed, but how those criteria are applied possibly could be changed, she adds.

"We want to make sure that the case management credential reflects the field," asserts CCMC chair **Patricia McCollom**, MS, RN, CRRN, CDMS, CCM, CLCP, who points to a demonstrated growth in the number of case managers, especially hospital case managers.

When the CCM credential was initiated, the largest number of applicants came from the insurance industry and independent case management companies, she notes. "At this point, the largest number of applicants are from hospitals."

As the field has evolved, concerns have surfaced among hospital-based case managers regarding the relationship between their work responsibilities and the eligibility criteria for the CCM credential, she says.

In addition to evaluating the field as it exists, the task force is conducting a research project that will review the job descriptions from all applicants, McCollom says. "We are going to take a large number of the job descriptions and review those for consistency with what the research says. That may make a difference in how those criteria are applied."

Maronde says she fields numerous phone calls from potential applicants asking if a certain certification will guarantee them a job. "It won't, unless you are interviewing with an employer that requires it." According to her organization's latest survey, only 5% of employers require certification, while 70% prefer it.

That may be changing, however. While the process itself is voluntary, more organizations soon may require it, says **Catherine Mullahy**, RN, CRRN, CCM, national president of the Case Management Society of America (CMSA) based in Little Rock, AR. She emphasizes that CMSA, a national organization representing case management professionals from many disciplines and practice settings, does not administer or endorse any particular certification or credential. "We do, however, certainly support certification and encourage our members to pursue the one that best fulfills their professional needs," she says.

With so many certifications to choose from, Mullahy says, case managers need to educate themselves about the various ones available in order to make the best decision for their current and future career goals. "Our web site, www.cmsa.org, has general information on the various certifications."

Shannon Carter, executive director of Certification Boards, Perioperative Nursing in Denver, says her organization is in the process of conducting research into the value of its certification programs. "We are surveying certified nurses, noncertified nurses, and people who hire certified nurses to find out the value to them of that credential."

In addition to personal motives, pay differentials are becoming more evident between certified and noncertified nurses, Carter says. Her organization has certified 30,000 perioperative nurses, a small minority of whom are case managers.

Gilpin contends that the recent slowdown in the economy means that many case managers may not have the luxury of remaining in their current position.

In that instance, case managers may want to

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select a credential that is both nationally recognized and broad enough in scope to offer the most flexibility rather than a narrowly focused specialty or discipline-specific credential. "A specialty or a discipline-specific credential may limit a case manager's job opportunities to specific practice settings, whereas a credential such as the CCM tells an employer that the case manager has the skills and experience necessary to be an effective case manager in any practice setting," she says.

The current nursing shortage also is likely to have an impact, McCollom says.

"Simply put, case management is an advance practice, and if there are not people entering nursing, there won't be people in it long enough to assume that role," adds Gilpin.

Carter says that the managers she interacts with most indicate that if they had a choice between a certified nurse and a noncertified nurse, all other things being equal, they would prefer certification.

One question a case manager should ask is what the facility might require. But an even more important question is what are individual case managers seeking in terms of their future career goals? Maronde says. "We advise people to look at the content of the various programs and think about their career goals."

Maureen McKenna, RN, LSW, director of care management at Lifespan / Physicians PSO in Providence, RI, says the Credentialing Advisory Board for the Certification of Case Management Administrators recently initiated two new certification programs specializing in social work. Those exams are designed to gauge how current administrators are in health care trends and case management, she says. They also assess how well case managers interpret data and use the data to demonstrate the impact of their programs.

According to Maronde, if case managers want to practice "hands-on" case management that focuses on patient care, there are several certifications that fall in that area. On the other hand, she says, the CPHQ credential is a "renaissance credential" that covers a variety of related fields. "We advise that if you want to go into a more administrative role, this is the credential to seek."

Candidates seeking this certification typically go beyond patient-focused case management. "They may have case management as part of their responsibilities, but they probably are also doing quality and perhaps infection control and risk management," she says. "All of that content is on our exam, whereas some of the others are more focused."

Another consideration for case managers is whether to pursue an accredited program or a nonaccredited program, Maronde says. Some programs such as HQCB enjoy the National Commission for Certified Agencies accreditation. However, most do not.

Yet another question that arises is which combination of certifications to secure. According to Maronde, many case managers have both the CCM and CPHQ certification, while many others combine the CPHQ and the risk management credential. "Many of our case managers are also infection control practitioners. We have a lot of dual-credentialed people in our group."

The equation also varies according to geographic region. "If you are on either coast, you are much more likely to need a credential then if you are in the midsection of the country," contends Maronde. To date, there are not many state requirements regarding case manager certification. Florida currently requires risk managers to have risk manager certification. However, that requirement falls more in the category of certificate then certification, she says. Candidates simply take a course that runs 120 hours and take a test, she explains.

As states become more involved with case management, however, some may require staff to be certified in order to contract with an agency for case management services, Mullahy says.

"It gets very confusing for everybody," Maronde says. And it is likely to get even more complicated, she predicts. ■

LOS misleading indicator for hip fracture, some say

LOS 'not good indicator of how these patients do'

Discharge of hip fracture patients from the acute care setting to subacute and skilled nursing facilities should be based on the patient achieving specific functional milestones rather than on the desire to shorten length of stay, experts say. Unfortunately, current payment methodology has hospitals focused on length of stay as a quality indicator.

"Length of stay is really not a good indicator for how these patients do," argues **Kelly McDevitt**,

RN, MS, ONC, orthopedic clinical case manager at University of Colorado Hospital in Denver. The most effective treatment often is to get these patients relocated to their home environment rather than transferring them in three days to a nursing home where they typically sit for several more days, she says.

According to McDevitt, case managers or quality assurance staff are responsible for tracking length of stay for hip fractures. But the key is to have it coded correctly, she says. "A hip fracture can be logged in as a femur fracture, a hip fracture, or a pelvic fracture. It has to be coded correctly to pull up the data."

The focus on length of stay for these patients actually is counterproductive, says **Shirley Kennedy**, orthopedic case manager at St. Vincent Hospital in Santa Fe, NM. "This population is truly being underserved," she contends. "They usually have numerous other problems and are not in the best of health."

Because hip surgery for these patients is a trauma and not a scheduled surgery, there needs to be a fair amount of work-up, McDevitt points out. "They usually are not well enough to go right to surgery. The trick is getting them worked up quickly and getting them into surgery quickly so they can get up and out of bed fast." She adds that because these patients typically are older, with comorbidities such as cardiac disease, renal disease, poor circulation, or respiratory disease, sometimes taking them to surgery is not the best option.

"First, we have to make sure they can tolerate the surgery, and once we do the surgery, it is best to get them ambulating as quickly as possible afterward," she explains.

"We try to start our total joint replacements a month in advance of the surgery to gain optimal health status so the surgery goes smoothly," Kennedy says.

According to **Joseph Zuckerman**, MD, professor and chair of the NYU-Hospital for Joint Disease Department of Orthopedic Surgery in New York City, communication is one of the keys to establishing a true continuum of care. "If I operate on hip facture patients and they get transferred on day five to their home, I have to communicate that information to their doctor; it's very important that information gets transferred. If they go to the rehab center, then leave and go back to their original doctor, how does he grasp the issues that have arisen in the interim?"

According to McDevitt, this can be particularly challenging in larger organizations where there is sometimes insufficient follow-up with the primary care physician.

Her facility is considered a specialty hospital, and patients with complex medical issues often are transferred there because small community hospitals can't handle all of the potential complications, she says. If the information does not follow patients back to the community hospital, that can create problems, McDevitt adds.

Evidence-based pathway is needed

Zuckerman also maintains that patients with hip fractures should follow "an evidence-based multidisciplinary critical pathway."

"It definitely needs to be an evidence-based multidisciplinary pathway," concurs McDevitt. "There is no question about it." Physical therapy, occupational therapy, nursing, physicians, orthopedists, primary care physicians, as well as community nurses all should be involved in the care plan, she says.

Zuckerman says that one of the elements should be standardized evaluation when the patient is admitted. "There should be rapid recognition as to whether the patient should get to the OR quickly for the stabilization of any serious factors. Patients who go to the OR two days after admission have a higher mortality rate."

As for the surgery itself, that is difficult to standardize, Zuckerman says. "But we should stress prompt surgery, technically well done, rapidly progressive post-op care, thromboprophylaxis to prevent clots, [and] ambulation."

"If you restrict their weight-bearing status, you may as well leave them in bed," says McDevitt. "That puts them at an incredible risk, because they don't have good dexterity and balance." However, this area is very difficult to standardize in attempting to develop a pathway, she adds.

It also should be recognized that there is significant malnutrition in this population, Zuckerman says. "If they are admitted with a hip fracture and malnutrition exists, this is considered a comorbidity and a separate DRG, which increases the level of reimbursement. In other words, hospitals should want to identify this condition."

Antiresorptive medication is another key consideration. "If a patient has a heart attack, there is no way he leaves the hospital without having his cholesterol and blood pressure checked, and if need be, being put on meds," says Zuckerman. "There should be an analogy when we admit

patients with hip fracture.

"Clearly this is a risk factor for osteoporosis, but probably less than 20% of these patients leave the hospital being treated for osteoporosis," he adds. "Some in the medical profession question whether we could actually prevent osteoporosis, but we could clearly have an impact."

Kennedy says that when she reviews the medications the patients are taking, she often finds that they are on multiple medications that may counteract each other or are duplicates with a generic name on one label and brand name on the other. "They go to numerous doctors and self-medicate," she asserts.

"This truly is a multidimentional problem that desperately needs case and family management." She points out that fracture patients typically are frail and elderly, often demented, undernourished, with low socioeconomic status, little or no social or financial support, and often live in unsafe situation to begin with.

According to Kennedy, the families of these patients often are nearby but unaware of how poorly they function at home. "I am usually told, 'She lives by herself and does very well on her own, so we had no idea she was so bad off.'"

"We rarely have [members of] our wealthy population fall and break their hips, even if they are in their 80s or 90s," she adds. ■

Tracking excessive DRG payments falls on CMs

OIG estimates $52.3 million in overpayments

Hospital case managers responsible for discharging patients to post-acute settings should take note that many of these discharges violate the new transfer rules that went into effect two years ago. In fact, the Health and Human Services Office of Inspector General (OIG) estimates that Medicare paid approximately $52.3 million nationwide in excessive DRG payments to prospective payment system (PPS) hospitals as a result of erroneously coded discharges.

"In most hospitals, case managers are responsible for documenting the discharge planning arrangements," says **Deborah Hale**, president of Administrative Consulting Services in Shawnee, OK. "That is what the coder uses to assign the disposition code."

In the final rule, the Centers for Medicare & Medicaid Services (CMS) indicated that hospitals maintain their responsibility to code the discharge based on the discharge plan for the patient. If the hospital subsequently learns that post-acute care was provided, the hospital should submit an adjustment bill. However, the agency acknowledged that hospitals will not always know the disposition of patients.

"It is a crazy system, and it puts the hospital in a difficult position," Hale says. That is because hospitals often lack the resources to track patients once they are discharged. If case managers do their job well in planning for discharge by looking at all the options and knowing what all the possibilities are, that is about as much as they can do, she says.

According to the OIG, CMS has no controls in place to prevent excessive payments to PPS hospitals for erroneously coded patient discharges that are followed by post-acute care, such as care in a skilled nursing facility or a home health agency. There were more than 1 million discharges between Oct. 1, 1998, and Sept. 10, 1999, within the 10 specified DRGs. Of these discharges, 14,890 claims were followed by post-acute care treatment that fell within the window of time necessary to categorize the discharge as a qualified discharge / post-acute care transfer and met all of the criteria necessary to potentially result in an overpayment, the OIG said.

Medicare payment rules provide that, in a transfer situation, payment is made to the final discharging hospital and each transferring hospital is paid a per-diem rate for each day of the stay, not to exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

As of Oct. 1, 1998, a discharge from a PPS hospital with one of the 10 specified DRGs to a post-acute care setting is treated as a transfer case. The applicable post-acute care settings include: a hospital or hospital unit that is not reimbursed under PPS, a skilled nursing facility, or home if there is a written plan of care for the provision of home health services and the services begin within three days of the discharge.

Reimbursement for qualified discharges is made under one of two payment methods, each of which is designed to match more closely the reimbursement to the hospital's cost of providing care to the patient. In the event that the cost of providing care to a patient meets the criteria to be deemed an outlier, additional payment is allowed

for the qualified discharges.

For DRGs 014, 113, 236, 263, 264, 429, and 483, hospitals are reimbursed at a graduated per-diem rate for each day of the beneficiary's stay. Under this calculation, the full DRG payment amount is divided by the mean length of stay for the specific DRG to which the case is assigned. Twice the per-diem amount is paid for the first day, and the per-diem rate is paid for each of the remaining days, not to exceed the full DRG payment.

For DRGs 209, 210, and 211, the reimbursement is calculated differently. On day one of a post-acute transfer, hospitals receive one-half the DRG payment amount plus the per-diem payment for the DRG. For each subsequent day prior to transfer, hospitals receive one-half the per diem up to the full DRG payment.

In addition to recovery of overpayments, the OIG recommends that CMS establish edits in its Common Working File to compare beneficiary inpatient claims potentially subject to the post-acute care policy with subsequent claims. The agency says this will allow potentially erroneous claims to be reviewed and appropriate adjustments to be made to the discharging hospital's inpatient claim. CMS officials concurred with these findings and recommendations. ■

Reform needed to save flagging health system

Communication, accountability are the keys

The health care system as we know it could experience significant difficulties over the next few months, says **Brian Klepper**, PhD, president of Healthcare Performance Inc. in Jacksonville, FL.

He cites rising health care premiums and a flagging economy as reasons the health care industry is in trouble. But the system can be fixed, and case managers are likely to have a big role in the solution, Klepper says.

Those assertions are backed up by a group of reinsurers, providers, and HMO representatives who came up with seven principals for how to fix the system, and case managers are likely to have a big role in the solution, Klepper says.

Among the issues they called for were uniform adoption of best practices and public availability of performance information.

"We need to find ways to eliminate variabilities in the system, through traffic controllers who are essentially case managers. The only way it can be done is if the case managers have guidelines to follow and the authority and buy-in they need," he says.

A major cause for problems within the health system is soaring health insurance premiums that have gone up double the rate of inflation for the past four years, he says.

"This year, the premium increase that has been leveled on employers is four times inflation, about 18% to 20% for large businesses and 30% to 50% for small business," Klepper says.

Rising premiums were no problem when the economy was prospering, but now that the economy is in a recession, business leaders are saying they will significantly increase employees' share of the cost, Klepper says, predicting a dramatic increase in the number of uninsured, beginning this month. "Nobody who makes $35,000 a year can afford to pay $7,000 a year for family coverage," he adds.

He predicts a big increase in the number of emergency room visits, and a spike in the inpatient days in the public hospitals as private hospitals stabilize patients and send them to public hospitals.

"Since 40% of American hospitals are already running in the red, if you get a spike in inpatient costs and a reimbursement vacuum, they are going to start to go under," he says.

Klepper has operated a health care consulting practice offering operational audits and business development services. This has given him a bird's-eye view of the system, he says.

"As a result of the way health care has grown up, it's become Wyatt Earp land. Everybody is out there for himself. Everybody is trying to make money. Everybody is less interested in the system than they are in their specific benefits from the system. That's why the system is getting ready to fail," he says.

The tremendous variation among providers in the quality of care and lack of accountability among providers, insurers, and patients has put the system in jeopardy, he says.

"If we keep the existing system, there have to be new disciplines that everybody buys into — all stakeholders, including consumers. We must say that we are all going to use the standards and be responsible for the choices we make," Klepper says. ■

Cover your bases with EMTALA algorithm

Are you curious about how much your staff really knows about the Emergency Medical Treatment and Active Labor Act (EMTALA)?

A survey from the Department of Health and Human Services provided some insights. *The Emergency Medical Treatment and Active Labor Act: Survey of Hospital Emergency Departments* (EDs) surveyed ED staff.

"Key findings were that most staff members were familiar with EMTALA requirements, but not all were aware of recent policy changes," says **Denise Casaubon**, RN, owner and president of DNR Consultants, a Fountain Hills, AZ-based company specializing in health care corporate compliance.

Here are key findings:

• **Staff need a better understanding of definitions such as "emergency medical condition" and "medical screening examination."**

Conduct review to determine compliance

Casaubon advises you to conduct clinical record reviews for compliance. "Draft a tool that includes the required EMTALA documentation elements," she explains.

"Then audit the clinical records to discover what areas staff need to improve." Observe staff during the course of business with regard to EMTALA requirements, she says.

"Is requesting insurance information delaying the medical screening examination?" Casaubon asks.

"Are patients being logged in correctly? Is all of the required information documented in the log?" The survey brings home the need for continuous inservices and training, she says.

Casaubon recommends holding at least two inservices a year for staff.

• **Staff had adequate knowledge about many areas of EMTALA.**

Strengths included a basic understanding of "patient dumping" and increased communication between sending and receiving hospitals, she reports.

However, only 70% of those surveyed knew that transfer records must be kept for five years and that hospitals are forbidden from retaliating against employees who report violations or refuse to authorize inappropriate transfers, says Casaubon.

• **Specialists and part-time staff lacked knowledge of EMTALA.**

The report showed that only 25% of on-call physicians have received training in EMTALA.

According to **Todd Taylor**, MD, FACEP, an attending ED physician at Good Samaritan Regional Medical Center in Phoenix, this is the "major fertile ground" for EMTALA violations right now.

"This is partly from a lack of guidance from [Centers for Medicare & Medicaid Services (CMS)] on what is required, and partly due to hospital and medical staff's inability to reach viable solutions," he says.

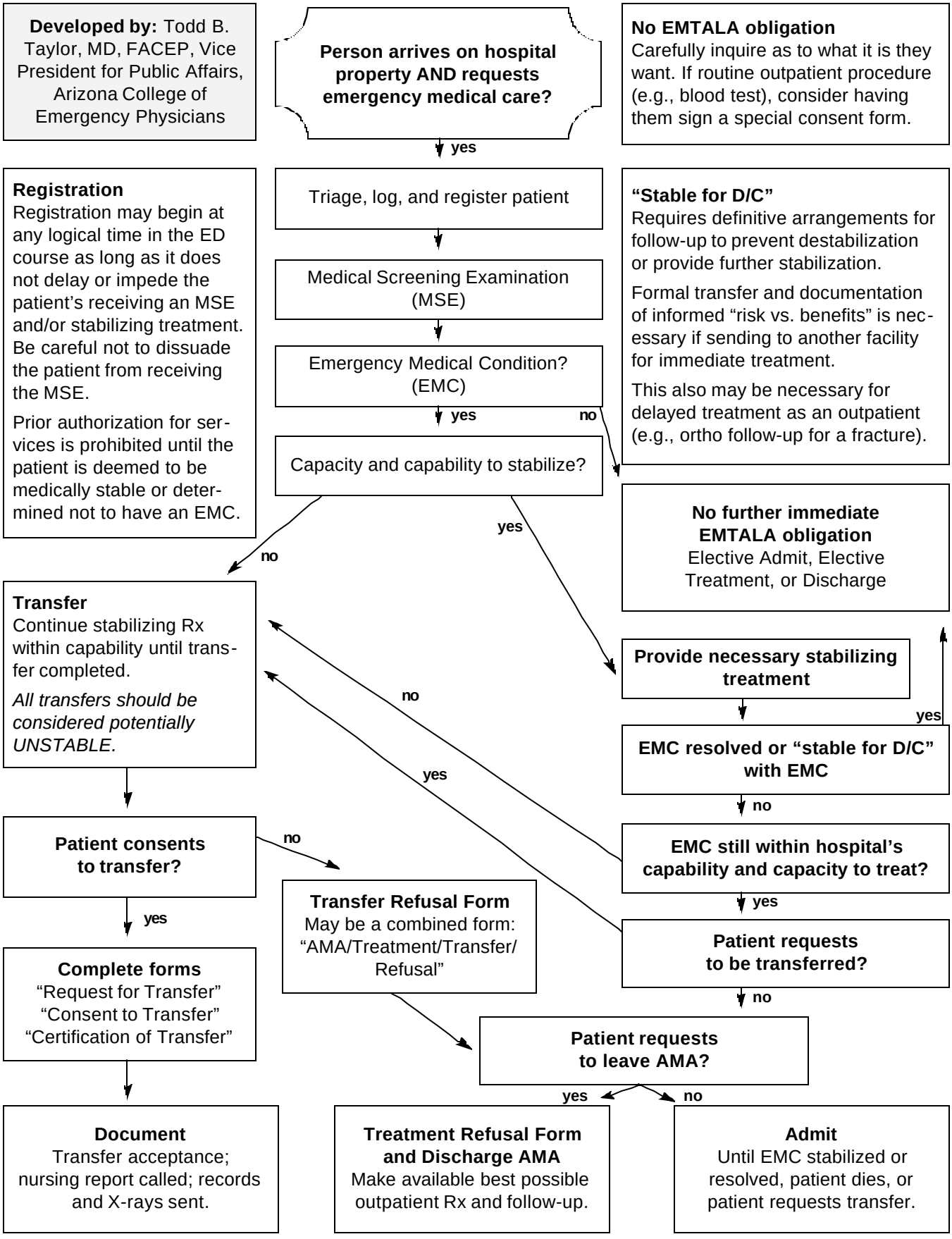
Go to CMS web site

• **There is a lack of knowledge about recent changes in guidelines.**

According to the report, only 65% of ED directors knew about interpretive guidelines published by the Health Care Financing Administration (now CMS) in June 1998.

(Continued on page 9)

EMTALA/COBRA Algorithm



EMTALA Keep it Short and Simple (KISS) Principles

For the hospital staff and emergency physicians inquiries:
• Do you want to see a doctor?
• I'll take you to the emergency department (ED).

ED:
• Log ALL patients.
• Medical screening exam for *all* patients by physician.
— If not, document why
— Left without treatment
— Refused
• Treat *all* patients to a reasonable disposition in the ED.

Transfers:
• Obtain acceptance from the receiving facility and complete a transfer form on ALL patients not otherwise being routinely discharged.
• Accept ALL transfers if the hospital has the capacity *(bed available and ever done it before)* to treat the presenting problem. If not, document why.

Reporting:
• Set up a system for reporting suspicious transfers.
• Report ALL suspicious transfers to you and ALL suspicious refusal to accept outgoing transfers.
• Document ALL incoming and outgoing transfers.

EMTALA *KISS* PRINCIPLES

For the medical staff physician

If you are called — you are chosen if on-call for the ED:
• Respond appropriately: No excuses, no complaints.
• The emergency physician dictates appropriateness unless or until you assume care of the patient.

Transfers:
• Accept ALL transfers if the hospital has the capacity *(bed available and ever done it before)* to treat the presenting problem. If not, document why.
• Obtain acceptance from the receiving facility, and complete a transfer form on ALL patients not otherwise being routinely discharged.

ED Patient Follow-Up:
• Do what you agreed to do later or come to the ED.
• Do not demand payment up front or refer back to the ED if unable to pay or a non-contracted health plan.

Reporting:
• Set up a system for reporting suspicious transfers.
• Report ALL suspicious transfers coming to you and ALL suspicious refusals to accept outgoing transfers.
• Document ALL incoming and outgoing transfers.

How can I help you with this patient?

Source: Todd Taylor, MD, FACEP, Good Samaritan Regional Medical Center, Phoenix.

Casaubon recommends using the Medicare Learning Network on the CMS web site (www.hcfa.gov/medlearn) as a resource.

"The Medicare Learning Network allows the user to search and get information on popular topics such as EMTALA," she says.

"It is easy to use and very informative. You can also keep abreast of the changes by checking the *Federal Register* weekly or monthly," Casaubon says.

As a health care professional, you need to keep abreast of recent changes, she urges.

"For example, the definition for hospital campus recently changed," she notes.

Review new definitions

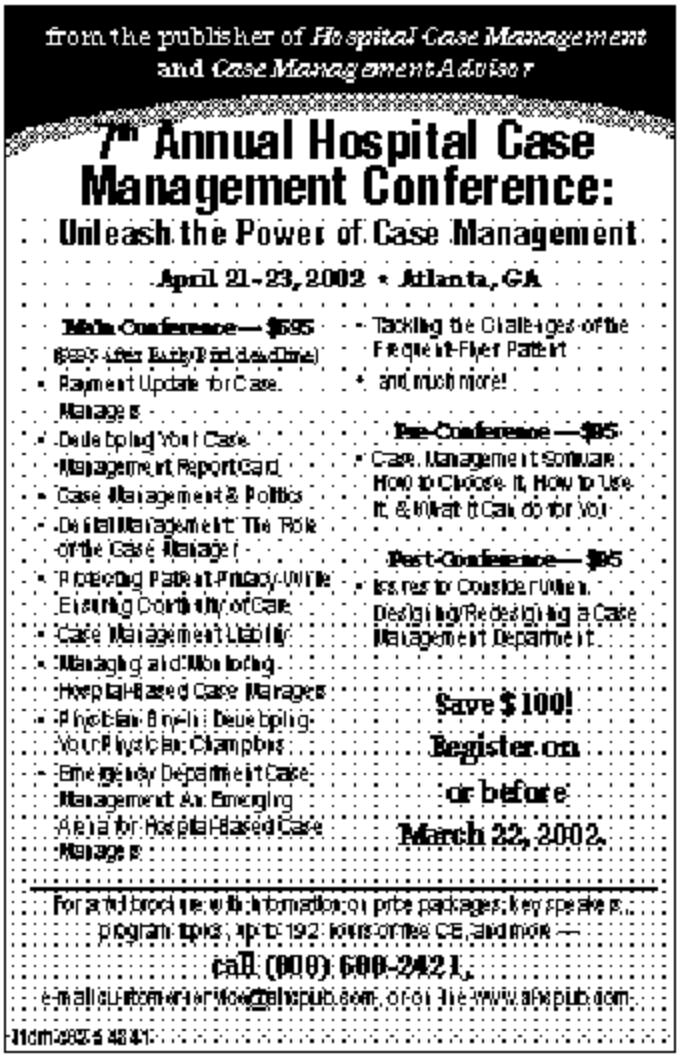
Casaubon provides a review of the new definition: A hospital campus is defined as a physical area immediately adjacent to the hospital main buildings, other structures, and areas not strictly contiguous to main buildings but located within 250 yards of the main building [42 CFR 413.65 (a)(2)]. Parking lots, sidewalks, and driveways on hospital property are considered to be part of the hospital for EMTALA purposes, she adds [42 CFR 489.24(b)].

Focus should be on hospital policies

However, Taylor argues that education efforts should be focused on hospital polices, not EMTALA itself.

"Focusing on EMTALA training could leave the application of those principles up to individuals rather than in following hospital policy," he explains.

"It is important that the staff understand their hospital policies, not whether they are aware of the latest CMS bulletin," Taylor adds.



What the staff actually need to know about the EMTALA regulation is relatively little, says Taylor.

He developed a "KISS" (Keep It Short and Simple) outline to use during inservices. **[See "EMTALA Keep it Short and Simple (KISS) Principles," p. 9.]**

Designate a compliance officer

The complexity and frequent updates of the law have forced most hospitals to designate a "compliance officer" responsible for keeping up with EMTALA, according to Taylor.

"The survey revealed that formal EMTALA training was not universal," he acknowledges. "But in reality, EMTALA compliance principles now are standard operating procedures for hospital EDs, and formal training is less important than in the past."

You must have a single referral resource for difficult EMTALA questions and situations, such as when to report suspected violations, Taylor points out.

"It would be impossible for every staff member to be an expert in EMTALA," Taylor says.

"In my experience, a little knowledge can do more harm than good," he adds.

Taylor recommends the use of an algorithm to use for most EMTALA situations. **(For EMTALA/COBRA Algorithm, see flowchart, p. 8.)**

"When patients fall off of this algorithm, the staff need to know who to call for help," he says.

"An EMTALA compliance officer is almost mandatory in the current regulatory environment," he explains.

[For more information on educating your staff about EMTALA, contact:

• ***Denise Casaubon**, RN, DNR Consultants, 16217 Balsam Drive, Fountain Hills, AZ 85268. Telephone: (480) 816-6695. Fax: (480) 836-8185. E-mail: casaubon@qwest.net.*

• ***Todd B. Taylor**, MD, FACEP, 1323 E. El Parqué Drive, Tempe, AZ 85282-2649. Telephone: (480) 731-4665. Fax: (480) 731-4727. E-mail: tbt@compuserve.com.*

A complete copy of the report, The Emergency Medical Treatment and Active Labor Act: Survey of Hospital Emergency Departments *(OEI-09-98-00220, 1/01) can be downloaded at no charge at the Office of Inspector General/Office of Evaluation and Inspections web site: www.dhhs.gov/progorg/oei. Click on "Search and Report," "Categorical Listing Search," and scroll down to find the report's title under "EMTALA."]* ■

Share your hospital's pathway successes

Hospital Case Management welcomes guest columns about clinical path development and use.

Articles should include any results (length of stay, cost, or process improvements) that use of your pathway has helped achieve and should be from 800 to 1,200 words long.

Send your article submissions to:

Russ Underwood, Managing Editor, *Hospital Case Management*, P.O. Box 740056, Atlanta, GA 30374. Telephone: (404) 262-5460. Fax: (404) 262-5447. ■

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Office CM program draws praise from physicians

Program helped decrease inappropriate admissions

A medical office case management program that began in July at Sutter Health Central in Sacramento, CA, is drawing praise from initially reluctant physicians and offering veteran case managers a new and particularly enriching caregiving opportunity.

"I really find great value in this position," says **Bernadette Damper**, RN, BSN, A-CCC, a medical office case manager for Sutter Physicians Alliance who has been a nurse for 26 years and a case manager for the past nine. "This is the most useful I have ever felt."

One of the physicians with whom she works recently told Damper that he and his colleagues at first couldn't understand why a case manager was needed in their office. Now, Damper adds, the physician says, "We'd love you to be here five days a week all year."

Damper's assessment of the program is that it has provided "the missing link" for other Sutter initiatives, such as the chronic care program and the case management expertise provided in the hospital and in skilled nursing facilities. **(See *Hospital Case Management*, April 2001, p. 59.)**

"It has really enhanced communication with the rest of the continuum of care team," Damper says. "If the case manager in the hospital is having difficulty persuading a patient who needs more care than can be given at home, [the case manager] can call me, who might know the family better, and we can collaborate. If a patient is not doing well at home, and [the caregiver] sees that something needs to be addressed but can't count on the patient to communicate that, [the caregiver] can call me."

"I can be there during the physician visit."

When there is a change in the patient's medication regimen, Damper notes, she can inform the caregiver, as well as alert Sutter's chronic care team, which can meet with the patient at home to provide additional information.

The medical office case management program began as a way to add value to physicians' participation in the Sutter Physicians Alliance, says **Jan Van der Mei**, RN, continuum case management director for Sutter Health Central. In view of the resistance that some physicians have to being in a managed care organization, she notes, "we felt it was important to be aligned with the physicians to support them."

Survey physicians' opinions

Before starting the program, Van der Mei says, Sutter Health sent physicians a survey to gauge their opinions on such issues as whether it was easy to place a patient directly into a skilled nursing facility or to manage the care of patients who make frequent visits to the emergency department (ED).

The results of the survey indicated that physicians believed there was room for improvement in several areas. For example, 85% disagreed with the statement that management of patients who frequent the ED is easy, and 77% disagreed with this statement: "I do not have to spend a great deal of time with certain complicated patients who primarily have social issues." **(See survey results, p. 13.)**

At the program's six-month point, Van der Mei adds, another survey will be done to see if the case management initiative has made a measurable difference.

The following strategic objectives were established for the program:

- **Increase patient satisfaction.**

Sutter Health already has distributed some patient satisfaction surveys, and the responses have been positive, she says. The survey process,

however, is a "work in progress," Van der Mei notes. "Sometimes the case manager talks to the patient, sometimes to the caregiver, so finding the right person to survey has been a challenge."

It also is difficult at times for the patient to connect one of the various professionals she or he dealt with to the case manager referred to in the survey, Van der Mei adds. "They may have one or two contacts with the case manager. We're trying to improve the process of helping patients know who the survey is about."

• **Decrease primary care physician (PCP) visits per 1,000 patients by actively assisting with complicated cases.**

The idea, Van der Mei notes, is that patient issues more social than medical in nature could be handled by the case manager, eliminating the need for some physician visits.

• **Enable closed practices to open to new members.**

"We've had a huge problem with closed practices," she says. "I'm not sure if we can impact that, but one of the hopes is that by helping manage complicated cases, [the case management program] will decrease the caseload to the point that some closed practices could be reopened."

• **Avoid inappropriate admissions.**

When a caregiver comes into the office and says, "I can't deal with Mom anymore," there may be a tendency for the physician to admit the patient to a hospital because he or she doesn't know what else to do. A case manager can help in such situations by, for example, arranging a nursing home placement, Van der Mei adds.

• **Decrease the volume of ED visits.**

"Some patients use the ED as a physician's office," she says. "Case managers can work with the physicians to develop a contract or a care plan for the patient, which the case manager can help implement or support."

'Contract' promotes compliance

Sutter Health issues a report that identifies patients who are noncompliant, meaning they repeatedly disregard physician instructions regarding medications or other issues, Van der Mei explains. That might mean, for example, habitually going to the ED to get more migraine medication at the last minute, rather than getting the drug through the physician's office, she says.

Although such action is rarely taken, patients who abuse the system can be disenrolled from the physician practice and from the managed care group, Van der Mei adds.

The patients that physicians initially thought to refer to their new case managers were those with mental health issues, she points out, and the fit was a good one.

"Most of the managed care contracts have mental health 'carved out,' and it is difficult to find who your HMO mental health providers are," Van der Mei says. "The patients were not able to get care, when you're severely depressed, you don't feel like making 10 calls [to find the appropriate provider]." The office case managers, she adds, were able to help navigate the HMO carve-outs and get the proper care for those patients.

Although physicians initially were skeptical about the case management program, Damper says, they now recognize that it can make a positive difference in their patients' outcomes. Her own interactions with patients and caregivers have ranged from helping decipher the changes in copays for Medicare HMOs to taking a proactive approach to nursing home placement, she explains.

Some medications that formerly were covered by Medicare are no longer covered, Damper points out, and some are covered but with different copays than before. She has helped find solutions for patients who were noncompliant because of financial concerns regarding their medications, she notes.

"With some patients, we need to find out if we can substitute a medication," Damper says. In other cases, she says, "we get in touch with the drug company representative and see if there is a [financial assistance] program they can go on." Many drug companies will supply free medication to a patient if it's been determined the person needs a specific drug and can't afford to buy it, Damper adds.

In other cases, she says, a complicated drug regimen needs to be simplified or explained. That could involve a referral to Sutter's education program for diabetics, for example.

The goal with nursing home placements, Damper notes, is to encourage physicians to refer patients to her when the patient appears to get weaker with each visit, or when the caregiver looks haggard and is not coping as well as before.

"I like to get involved as early as possible so the family and the patient have more choices," she says. The patient may be eligible for long-term

(Continued on page 14)

Sutter Health Central Case Management

PCP Pre-Program Survey
Total Results – SIP, SMG, SWMG

PLEASE ANSWER THE FOLLOWING:	Agree	Not Sure	Disagree	N/A or No Answer
The ability to place a patient directly into a Skilled Nursing Facility is easy.	22%	9%	63%	6%
The ability to obtain home health, infusion therapy or durable medical equipment for my patients is easy.	26%	9%	65%	0%
Management of my patients who frequent the ED is easy.	6%	3%	85%	6%
I do not have to spend a great deal of time with certain complicated patients who primarily have social issues.	17%	6%	77%	0%
I do not have many non-compliant patients.	9%	14%	71%	6%
My patients receive adequate education and support.	20%	9%	71%	0%
Linkages to the SNF team for admissions and follow-up care post discharge are easy.	9%	9%	19%	63%
Linkages to the Hospitalist team for admissions and follow-up care post discharge are easy.	26%	8%	40%	26%
It is easy to refer patients to the following Sutter programs and community resources:				
SMF Diabetes Education	34%	9%	57%	0%
Sutter Chronic Care Program	34%	26%	37%	3%
CHF disease management	21%	38%	35%	6%

Source: Sutter Health Central, Sacramento, CA.

MediCal coverage, Damper explains, but because of the waiting period required might have to go in as a private-pay patient if the placement is done at the last minute.

Arranging a placement when the patient can wait at home for a couple of weeks also makes it more likely that a geographically convenient location can be arranged, she says.

Having a case manager involved can prevent a patient who may need only temporary placement in a nursing home from being admitted and "forgotten," Damper points out. "I had a patient with rheumatoid arthritis who couldn't walk to the bathroom because of the amount of pain she was experiencing. The caregiver couldn't manage her."

The patient was admitted to a nursing home, she says, but with the purpose of working on pain control and mobility. "With some adjustments we were able to make, she is now on a pain control regimen that works," Damper adds.

"I was able to keep abreast of her condition, so she was able to get in and out and be back home with her family for the holidays," she says.

Medical office case managers can play a key role in addressing end-of-life issues before a patient is in the ED being put on life support, she notes. "If a patient is losing the ability to take oral nourishment, we can address what the person's wishes are, so when the time comes, things aren't done that he or she didn't want done."

Before assuming her position, Damper says, she had been a medical/surgical case manager for Sutter, performing utilization management of both bed days and resources.

She also had discharge planning responsibilities. Asked to compare her previous job with her current one, she notes that while her mission is much the same, the way it is perceived is vastly different.

Ensuring the best for the patient

"One of the purposes of my being [in the medical office] is to ensure that the patient is treated in the most efficient location, at the appropriate place at the most appropriate time, Damper points out. "We still have utilization on our minds."

But unlike hospital case managers and discharge planners, she's no longer the "firing point" of families who think a patient is being released too soon and physicians who think they're not getting to make decisions, she says.

"I'm basically doing the same thing," Damper adds, "but because it's a noncrisis situation, what I'm doing is perceived better."

[For more information on Sutter's medical office case management program, contact:

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CE questions

1. Which of the following credentials is administered by the Healthcare Quality Certification Board in San Gabriel, CA?
   A. Case Management Administrator, Certified (CMAC)
   B. Certified Professional in Healthcare Quality (CPHQ)
   C. Case Manager, Certified (CMC)
   D. Certified Rehabilitation Registered Nurse (CRRN)

2. List the numbers of perioperative nurses certified by Certification Boards, Perioperative Nursing, in Denver, according to executive director Shannon Carter.
   A. 10,000
   B. 20,000
   C. 30,000
   D. 40,000

3. According to Joseph Zuckerman, MD, professor and chair of the NYU-Hospital for Joint Disease Department of Orthopedic Surgery in New York City, although hip fracture is a risk factor for osteoporosis, "probably less than 20% of these patients leave the hospital being treated for osteoporosis."
   A. true
   B. false

4. Starting Oct. 1, 2001, Medicare increased its payment rates for inpatient hospital care by what percentage?
   A. 20%
   B. 12.5%
   C. 5.3%
   D. 2.75%

Medicare to increase inpatient payment rates

Medicare increased its payment rates for inpatient hospital care by 2.75% starting Oct. 1, 2001. The increase for fiscal year 2002 affects about 4,800 acute care hospitals that are paid under Medicare's inpatient prospective payment system. The new rate, which reflects the law's requirements for updating Medicare payment rates, was published in a final rule in the Aug. 1 *Federal Register*. Medicare law pegs the annual updates for acute care hospitals for fiscal year 2002 to the estimated increase in the hospital marketbasket — the inflation rate for goods and services used by acute care hospitals: -0.55 percentage points.

For fiscal year 2002, the hospital marketbasket is projected to increase by 3.3%. The update is 2.75%. The final rule does not address provisions in the proposed rule dealing with expediting the incorporation of new medical services and technologies in the inpatient prospective payment system coding and payment methodology. The Centers of Medicare & Medicaid Services will address this issue in a separate final rule to be published later this summer. ▼

Medicare to pay for ED observation

The long-awaited proposed rule on payment for the emergency department (ED) observation services from the Centers for Medicare & Medicaid Services (CMS) has been published, and you probably will be pleasantly surprised at the outcome. "The [CMS] ruling was in our favor," announces **Sandra Sieck**, RN, director of cardiovascular development at Providence Hospital in Mobile, AL. "Now we can provide better patient care without financial restraints."

The rule proposes to create a new payment group for observation services for patients with chest pain, asthma, and congestive heart failure. The proposed ruling was published in the Aug. 24, 2001, *Federal Register*. The final rule became effective Jan. 1, 2002.

Raymond D. Bahr, MD, FACP, FACC, president of the Baltimore-based Society for Chest Pain Centers and Providers, reports that the group got CMS's attention by building a consensus among a dozen groups, including the Irving, TX-based American College of Emergency Physicians. "At an early stage, we were able to engage [CMS]

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Editorial Questions

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

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administrators who wrote the previous outpatient regulation," says Bahr, who is also medical director of The Paul Dudley White Coronary Care System at St. Agnes HealthCare, also in Baltimore. "We made them aware of the medical advances which have taken place in the care of patients with acute coronary syndrome."

He gives the example of current chest pain evaluation in the ED, which includes an "attack" approach for patients with acute myocardial infarction (AMI), but also an observation period to assess other patients. "This approach provided evidence for reduction in a number of missed AMI patients being sent home, as well as a significant reduction in the number of inappropriate admissions to the hospital," he adds.

This system of risk stratification was included in the new American College of Cardiology / American Heart Association guidelines for patients being evaluated with unstable angina and non-ST- segment elevation myocardial infarction, he notes.[1] To use this approach effectively, EDs needed to have appropriate reimbursement, Bahr urges.

Although observation centers have been declining due to lack of reimbursement, he expects that to change. "With the proper reimbursement, we expect to see a renewed interest in observation services that will result in exponential growth of chest pain centers." Bahr predicts that the number of chest pain centers, currently 1,300, will double over the next year or two.

Reference

1. ACC / AHA Guidelines for the management of patients with unstable angina and non-ST-segment elevation myocardial infarction: Executive summary and recommendations. *J Am Coll Cardiol* 2000; 36:970-1,062. ▼

Bio attacks pose new risk challenges

Treating patients of biological and chemical attacks can pose a different kind of challenge for hospitals from a risk management perspective, **Jim Bentley**, senior vice president of the Chicago-based American Hospital Association, recently told members of the American Society for Healthcare Risk Management (ASHRM).

Speaking at ASHRM's annual meeting in Boston, Bentley said changes to triage procedures for treating mass casualties from such attacks could create new areas of liability. For example, it might be necessary for health care providers to give treatment priority to the most survivable patients, he said. Hospitals should include risk management in the preparation of disaster preparedness plans. ■

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. ■

PATIENT SAFETY ALERT™
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Anthrax outbreak forces closer focus on patient safety

Facilities may have to revisit preparedness plans

The recent anthrax bioterror attacks have been a rude awakening for health care professionals across the country; they now know that what they once considered a dim possibility now is a reality.

And while the threat seems to have died down, it has raised the specter of other, even more serious bioterrorism events involving infectious agents such as smallpox.

What's more, caring adequately for patients in such emergencies may have ramifications that extend far beyond the health and well-being of those patients. They include the issue of possible malpractice lawsuits, such as the one filed by the son of one of the anthrax victims against the hospital that had treated his father — ostensibly for not diagnosing his disease quickly enough to save him.

Professionals concerned with patient care have redoubled their efforts to ensure their disaster response plans will optimize the well-being of their patients.

Taking another look at disaster planning

"After the events of Sept. 11, we took another look at our disaster response plan, which covers any community or national disaster — chemical exposures, bioterrorism, [or natural disasters] — because of our proximity to [Dallas-Fort Worth] Airport," says **Jane Meridith**, RN, assistant vice president of nursing for Baylor Medical Center at Grapevine (TX).

The plan, created fairly recently, was rewritten to conform with the Hospital Emergency Incident Command System, used widely by fire departments and emergency medical services across the country. "The Joint Commission [on Accreditation of Healthcare Organizations] says that if we can get the hospitals to use it, we will then all be using the same lingo," she explains.

"Another plus is that, given the transient nature of health care, we wouldn't have to retrain new staff when people leave," Meridith says.

Subcommittee formed

In the wake of the terrorist attacks, the hospital immediately put together an emergency management subcommittee that meets weekly. It consists of the key people who would be needed to ensure that everything is in place if a bioterrorism event were to occur.

"We started increasing our supply of antibiotics, and we put in place additional security measures, such as being able to lock down the facility, making sure everyone was wearing proper ID badges, and scrutinizing who's in the building and why," says Meridith. "We limited access in the dock area as well."

Meridith's team also met with the regional head of emergency management for the Texas Department of Health to identify, among other things, equipment and education needs.

As part of a larger system, the Grapevine facility also has determined which resources can be shared with other facilities, she says.

"We have also met with and have scheduled training for key staff — anyone who could possibly come in contact with someone who has been exposed. That includes security, ED staff, administrative supervisors, front desk receptionists, PBX operators, and volunteers," Meridith observes.

Emergency management staff have identified a core team of individuals who actually would be responsible for decontamination in the event of exposure. "They've had extensive training by OSHA [the Occupational Safety and Health Administration], and hands-on training with the equipment that would be used," she notes.

Meridith says the hospital's efforts fall into three key areas:

- educating staff;
- ensuring the appropriate facilities and equipment are available to decontaminate patients;
- encouraging all employees to be alert to what's going on in the surrounding environment.

Detailed bioterror component

The response plan at Baylor Grapevine is organized into "annexes," and the bioterrorism annex is extremely detailed.

Aimed at the four diseases most likely to occur as a result of bioterrorism (anthrax, botulism, plague, and smallpox), the annex first outlines procedures, which are subdivided into the following:

- Reporting Requirements and Contact Information (including phone numbers of internal and external contacts);
- Detection of Outbreaks Caused by Agents of Bioterrorism;
- Surveillance;
- Infection Control Practices for Patient Management (including isolation precautions, patient placement, patient transport and cleaning, disinfection and sterilization of equipment, and environment);
- Post-Exposure Management.

The annex then goes on to provide detailed information about each of the diseases, outlining etiology, modes of transmission, period of communicability, special planning information, decontamination of exposed patients, isolation precautions for exposed patients, isolation precautions for patients with disease, lab specimen handling / transport, vaccine availability, and post-mortem care.

"This has been a very positive process," says Meridith. "We have a better educated, better prepared staff. We're better prepared to take care of patients — both inside the facility and out."

While working hard to ensure optimum care for patients, it's equally important to prevent your staff from becoming patients. Hospital professionals must concern themselves equally with the health and safety of first-responders and others who may come in contact with these patients.

What sort of precautions should be taken? "There are, of course, isolation standards, which we always use," says **Jan Schwarz-Miller**, MD, MPH, director of occupational medicine for Atlantic Health System in northern New Jersey.

"Most of these were developed in response to HIV. The other concerns are respiratory and droplet and contact," she points out. "Unless it's cutaneous, anthrax is not passed by any of those routes. There's a tiny, tiny, tiny risk, so we do use contact precautions. Thank goodness, we do not need to worry about person-to-person spread."

What if we were faced with an outbreak of something more contagious? "That's a totally different story," Schwarz-Miller says.

"Then, it depends on how it's transmitted. A worst-case scenario would be something like smallpox, simply because we only have a certain number of negative-pressure rooms," she adds. "The number we have is more than adequate for what we consider to be a standard situation, but in an epidemic, there would have to be huge cohorting."

Don't forget the basics

No matter how complex your response plan is, it's critical to keep in mind the basic procedures that will help minimize the risk for all involved, says **Bonnie Barnard**, MPH, CIC, who heads up the patient safety task force at the national level for the Washington, DC-based Association for Professionals in Infection Control and Epidemiology Inc. (APIC).

"Your first concern is control of the immediate area," she asserts. "The second will be the air-handling system; that will be the route through which terrorists could achieve the greatest impact if they use these small-particle powders than can become aerosolized. If there were only two things that you could do, it would be these two."

Barnard reminds us that things could have been much worse had a more infectious agent than anthrax been used, and that it's important to be prepared for that eventuality.

"With anthrax, it's not spread from person to person," she notes. "If you do have something like smallpox, now you've opened a real can of worms."

In the case of such an attack, she says, hospital

epidemiologists will be very busy, indeed. "Proper isolation procedures must be followed," she explains.

"Right now, you should be making sure there are rooms available in your facility that are truly negative-pressure rooms, because if people are admitted with, say smallpox, they must be very carefully placed in those negative-pressure rooms," she says.

"There has even been talk that if you do see a case and have admitted that individual, the government may have to intercede and shut the hospital down; smallpox is very contagious. One case is an epidemic," Barnard adds.

Resources are available

Fortunately, a number of resources are available to help develop a response plan. APIC has published a bioterrorism readiness plan for health care facilities that can be found at www.apic.org. "It's very comprehensive; it walks you step by step through the components you should have in your plan," Barnard says.

Second, she advises, make sure you're on the Centers for Disease Control and Prevention's *Morbidity and Mortality Weekly Report* notification list. "That's where the most current information available on bioterrorism is found."

In addition, the Joint Commission on Accreditation of Healthcare Organizations has just published a new issue of *Perspectives* that focuses on emergency management planning, with a featured emphasis on "The need for a national bioterrorism response." It can be found at www.jcaho.org.

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HHS commits $50 million to better patient safety

In an unprecedented move, the U.S. Department of Health and Human Services has released $50 million to fund 94 new research grants, contracts, and other projects to reduce medical errors and improve patient safety.

This initiative, the first phase of a multi-year effort, will be concentrated in the following areas:

• **Supporting demonstration projects to report medical errors data**. This will include 24 projects for $24.7 million to study methods of collecting and analyzing data on errors.

• **Using computers and information technology to prevent medical errors.** Activities will include 22 projects for $5.3 million, to develop and test the use of computers and information technology to reduce medical errors, improve patient safety, and improve quality of care.

• **Understanding the impact of working conditions on patient safety.** Eight projects, to cost $5.3 million, will examine issues such as staffing, fatigue, stress, sleep deprivation, and other factors that can lead to errors. These issues have not been closely studied in health care settings.

• **Developing innovative approaches to improving patient safety.** These activities will include 23 projects for $8 million, and will involve health care facilities and organizations in geographically diverse locations across the country.

• **Disseminating research results.** Seven projects, costing $2.4 million, will help educate clinicians and others about the results of patient safety research. This work will help develop, demonstrate, and evaluate new approaches to improving provider education in order to reduce errors.

• **Additional patient safety research initiatives.** The Agency for Healthcare Research and Quality (AHRQ) will use the remaining $6.4 million for 10 projects covering other safety research activities, including supporting meetings of state and local officials to advance local patient safety initiatives and assessing the feasibility of implementing a patient safety improvement corps.

"This funding is incredibly significant," says **Gregg Meyer**, MD, director of the AHRQ's Center for Quality Improvement and Patient Safety. "One of the things that was made clear in the IOM [Institute of Medicine] report in 1999 was that, in

order to make dramatic improvement, we have to answer a great many questions. This is a bold initiative in answering these questions." Meyer also points out that "with this [commitment], AHRQ becomes the world's largest funder of patient safety research."

Meyer is quick to note that this agenda came not from researchers but from patients. "We took a very new and important approach in developing this agenda — we went to potential users. We went to patients, providers, professional associations, hospitals, health plans, and policy-makers. We asked: 'What are the important questions we could answer that will help you make it safer for patients?' This approach, in the long run, will be very important and will pay off handsomely in terms of having a real impact on the safety of health care."

Meyer adds that this investment not only will fund research by the best in the field, but it will yield very relevant information. The AHRQ web site (www.ahrq.gov) or the site www.quick.gov will provide a look at current patient safety research.

His goals for the initiative include improving patient safety on two broad fronts. "First, it will help us translate what is already known about improving safety into practice. Evidence-based practice reports really show what can be put into practice now; we can immediately translate what we know into practice and get an immediate effect. I'm talking on the order of 12 to 24 months; some of the efforts we've funded should already be making health care safer," Meyers says.

His second goal is to truly understand the epidemiology of and solutions to the patient safety problem. "We hope to make a down payment in this area," he says. "One of our most controversial initiatives has to do with the role of reporting. We're investing almost half of all the money into reporting — what works and what doesn't. That's very exciting."

Also exciting, says Meyer, is the fact that this is not a research initiative that will take five or 10 years to affect the lives of patients. "There are some more immediate benefits. We are pleased that Congress gave us the opportunity to do this research into what is such a huge challenge for the health care system."

[For more information, contact:

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Leapfrog compliance pays off for hospitals

Hospitals will begin to reap monetary rewards if they implement some specific patient safety initiatives backed by the Washington, DC-based patient safety improvement organization, The Leapfrog Group.

A consortium of Fortune 500 companies and other large health care purchasers, The Leapfrog Group will give $2 million toward hospital bonuses for using proven safety methods.

The two areas of Leapfrog's focus are computerized physician order entry systems and specifically trained intensive care physicians.

If employees from participating Leapfrog firms are hospitalized after Jan. 1, 2002, the insurer Empire Blue Cross and Blue Shield will pay compliant hospitals 4% more than the regular inpatient reimbursement rate.

The bonus rate will drop to 3% in 2003 and to 2% the year after that. ▼

NPSF taps Diamond as interim director

The National Patient Safety Foundation (NPSF) in Chicago has appointed board member Louis H. Diamond, MB, ChB, FACP, as interim director of programs. Diamond is medical director and vice president at The MEDSTAT Group, providing clinical oversight for the Ann Arbor, MI-based company's products.

The NPSF is an independent, nonprofit research and educational organization dedicated to the measurable improvement of patient safety in the delivery of health care.

The foundation seeks to identify risk throughout the health care system, analyze human and / or organizational factors that may lead to patient injuries, and implement actions that help providers and patients prevent injuries. ■

BIOTERRORISM WATCH

Preparing for and responding to biological, chemical and nuclear disasters

Flu or anthrax? First inhalational cases yield clues for clinicians to make the critical call

Use case history, blood work, X-rays, rapid tests

There is a postal worker in your emergency department (ED) with flulike symptoms.

That once insignificant observation about occupation and illness now triggers a detailed algorithm created by the Centers for Disease Control and Prevention (CDC) in Atlanta. **(See algorithm, p. 2.)** Is it flu or inhalational anthrax? Whether a realistic question or not, it is what many of your incoming patients may be asking — particularly if another wave of anthrax scares coincides with a nasty influenza season. Many of the initial symptoms are similar, but investigators dealing with the first inhalational anthrax cases have gleaned out key indicators that will help clinicians make the call.

"It is important to take a careful history from the [patients] when they present," says **Julie Gerberding**, MD, acting deputy director of CDC's National Center for Infectious Diseases. "If the [patients are] mail handlers in a professional environment — where they're dealing with large amounts of mail that is not their own — then the index of suspicion should be raised and more testing should be done to be sure there aren't additional clues to suggest that it is not a common viral infection."

Using the first 10 cases of inhalational anthrax as a baseline patient profile, the CDC reports that the median age of the patients was 56 years (range: 43-73 years), and seven were men.[1]

The incubation period from the time of exposure to onset of symptoms when known (seven cases) was seven days (range: five to 11 days).

The initial illness in the patients included fever (nine) and / or sweats / chills (six). Severe fatigue or malaise was present in eight, and minimal or nonproductive cough in nine. One had blood-tinged sputum. Eight patients reported chest discomfort or pleuritic pain. Abdominal pain or nausea or vomiting occurred in five, and five reported chest heaviness. Other symptoms included shortness of breath (seven), headache (five), myalgias (four), and sore throat (two). The mortality rate was 40% for the 10 patients, much lower than historical data indicated. Indeed, one of the critical reasons to recognize inhalational anthrax early is that it is far more treatable than originally thought.

The CDC gathered comparative data on the symptoms and signs of anthrax and influenza, finding, for example, that only 20% of the anthrax patients reported sore throat.[2] Flu sufferers report a sore throat in 64% to 84% of cases. Likewise, 80% of the anthrax cases reported symptoms of nausea and vomiting. That symptom is reported in only 12% of flu cases. Shortness of breath appears to be another key distinguishing symptom, affecting 80% of the anthrax patients but seen in only 6% of flu patients.

"One of the other clues that we are noticing is that the patients with inhalation anthrax actually do not have nasal congestion or a runny nose,"

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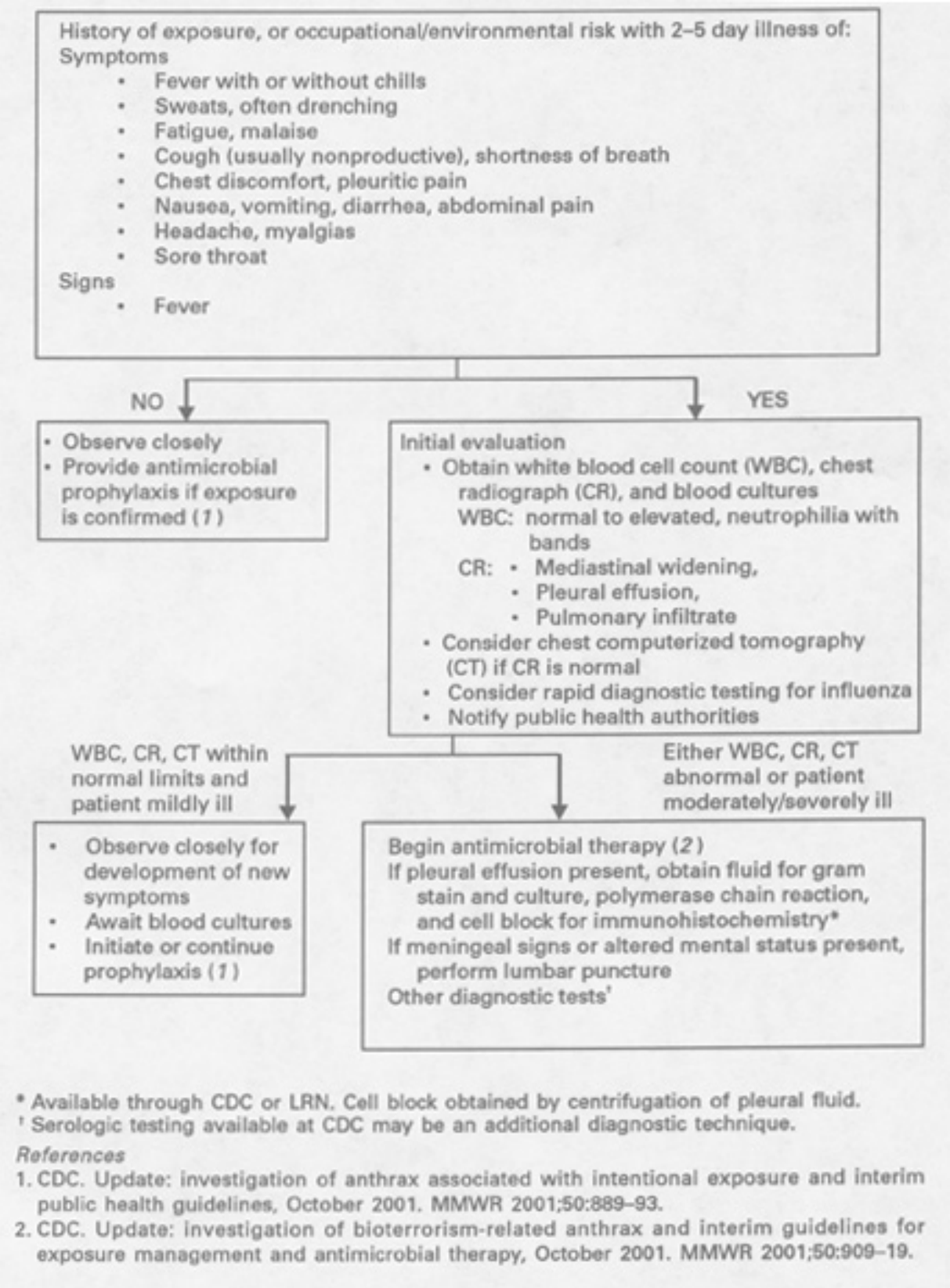
Clinical Evaluation of People with Possible Inhalational Anthrax



Source: Centers for Disease Control and Prevention. Update: Investigation of bioterrorism-related anthrax and interim guidelines for clinical evaluation of persons with possible anthrax. *MMWR* 2001; 50:945.

Gerberding says. "They don't have the symptoms of an upper-respiratory tract infection. They have a more systemic chest presentation, and that may be another distinguishing characteristic."

Another finding on initial blood work is that none of the inhalational anthrax patients had a low white blood cell count (WBC) or lymphocytosis when initially evaluated. Given that, CDC officials note that future suspect cases with low WBC counts may have viral infections such as influenza. Chest X-rays were abnormal in all patients, but in two an initial reading was interpreted as within normal limits. Mediastinal changes including mediastinal widening were noted in all eight patients who had CT scans. Mediastinal widening may be subtle, and careful review of the chest radiograph by a radiologist may be necessary, the CDC advises.

Complementing the CDC's effort, are the observations of the few clinicians who have actually seen inhalational anthrax cases come into their hospital systems. Two inhalational anthrax cases, both of which survived, were admitted to the Inova Healthcare System in Fairfax, VA (near Washington, DC).

"Clinically, I think the history of the people who presented here is useful," says **Allan J. Morrison Jr.**, MD, MSc, FACP, health care epidemiologist for the Inova system. "They stutter-stepped toward their pulmonary symptoms. That had some mild symptoms and then they were sort of 'meta-stable.' They were not relentlessly progressing. Then they progressed with symptoms more aggressively. Whereas with influenza — in our experience — once you start to get sick, it just keeps on progressing with very high fevers, chills, muscle aches, and pains. As a consequence, we feel there should be a good way to differentiate the two."

Since anthrax is a realistic concern in the Washington, DC, area, what about the aforementioned scenario of symptomatic postal workers in the ED?

"We would take a very aggressive history, not only of occupation but physically where they have been," Morrison says. "If they are symptomatic and have been in or work around a 'hot zone' — a location from which anthrax has either been cultured environmentally or patients have come from there — we will err on the side of being very aggressive about working up anthrax. By that I mean chest X-rays, chemistry profile, [etc.]"

In addition, the hospital system pushed early flu vaccination programs for staff and the surrounding community. "We want to move toward herd immunity," he says. "We are also working with our local hospitals to make sure that they have access to the rapid influenza tests. So for diagnosis — for obvious reasons — it is very helpful to make that distinction early."

One such rapid test is ZstatFlu (ZymeTX Inc., Oklahoma City), which the company claims can yield a diagnosis of influenza A or B some 20 minutes after a throat swab. The test detects neuraminidase, an influenza viral enzyme. However, Gerberding cautions clinicians not to rely solely on such tests. Rather, they should use the results of tests in combination with the patient history and clinical presentation, she says.

"So it is a constellation of history, clinical findings, and laboratory tests," she says. "Hopefully, when we get these all together, we'll be able to at least reduce the anxiety among some people and help clinicians diagnose those patients who really do require the antibiotic treatment. What we don't want to have happen is for everybody coming in with the flu to get an antibiotic because that undermines a whole other set of public health issues relating to antimicrobial resistance and proper management of influenza."

Even the vaccinated can still have flu

Complicating the issue is the fact that the flu vaccine efficacy can vary annually, but is usually 70% to 90% protective, says **Keiji Fukuda**, MD, a medical epidemiologist in the CDC influenza branch. Thus, depending on how well the vaccine matches the circulating strain, a certain portion of flu patients will tell clinicians they have been immunized. But in addition to vaccine breakthrough infections, there is a plethora of other viral and respiratory pathogens that will be creating similar symptoms, he says. In a somewhat sobering reminder — given that at this writing, the total anthrax cases remained in the double digits — Fukuda notes that a typical flu season will send 114,000 people to the hospital and 20,000 to their graves.

"There has been an awful lot of attention on the [anthrax] cases, but the bottom line is that there have been few cases, and these cases generally have occurred in a limited number of communities within a limited number of groups," he says. "And so the epidemiologic message is that anthrax really has not been diagnosed in most parts of the country, whereas we expect to see millions and millions of flu cases all over the place."

If facilities are faced with an onslaught of patients with respiratory illness there are several measures they can take, he notes. Those include:

- Reduce or eliminate elective surgery.
- Relax staff-to-patient ratios within the limits of your licensing agency.
- Emphasize immunizing staff so more staff are available.
- Identify ways to bring in extra staff to help out with the patients.
- Set up walk-in flu clinics to triage the patients.

Reference

1. Centers for Disease Control and Prevention. Update: Investigation of bioterrorism-related anthrax and interim guidelines for clinical evaluation of persons with possible anthrax. *MMWR* 2001; 50:941-948.

2. Centers for Disease Control and Prevention. Consideration for distinguishing influenza-like illness from inhalational anthrax. *MMWR* 2001; 50:984-986. ■

CDC moving quickly on smallpox front

Immunizations, training, vaccine dilution studied

Though officially stating it has no knowledge of any impending use of smallpox as a bioweapon, the Centers for Disease Control and Prevention (CDC) is scrambling with conspicuous speed to be ready for just such an event.

CDC workers from a variety of specialties are not only receiving smallpox vaccinations, they are being trained to give them to others using the old bifurcated needle scarification technique. And, even as creation of a new vaccine is fast-tracked, researchers are trying to determine if the current stockpile of 15.4 million doses can be expanded fivefold by simply diluting the vaccine.

Based on such actions, it is fair to say the agency is at least highly suspicious that the known stocks of smallpox virus are not safely ensconced in their official repositories in Russia and the United States.

"CDC is putting together a number of teams, which will probably total [more than] 100 employees, that could be quickly dispatched in a moment's notice to assist state and local health departments and frontline clinicians investigate suspect cases of smallpox," **Tom Skinner**, a spokesman for the CDC, tells *Bioterrorism Watch.*

"They are Epidemic Intelligence Service (EIS) officers, laboratorians, and others. Part of this includes vaccinating them against smallpox," he explains.

But while confirming that the CDC teams are being trained to administer the vaccine, Skinner would not specify who would be vaccinated following a smallpox bioterror event. "We have a smallpox readiness plan," he says. "Issues around vaccination are covered in that plan. That plan is being finalized. It is considered an operational plan. If we have a case tomorrow, it could be implemented. It covers who should be vaccinated and when."

The general consensus among bioterrorism experts is that those exposed would be vaccinated because the vaccine can prevent infection and possibly death even if given several days out. Likewise, health care workers and their family members would want vaccine if they were expected to care for the infected. Some aspect of quarantine would no doubt come into play because, unlike anthrax, it will be critical to separate the first smallpox cases and their contacts from the susceptible population.

Another aspect of CDC preparations includes the smallpox vaccine dilution study, which is being headed up by **Sharon E. Frey**, MD, associate professor of infectious diseases and immunology at Saint Louis University School of Medicine.

The vaccine, known as Dryvax, is no longer produced, but there are 15.4 million doses left. Frey and colleagues are looking at dilution studies that could maintain vaccine efficacy while increasing the available stock by millions of doses. In a study last year, Frey tried a one to 10 vaccine dilution, which would create a stockpile of more than 150 million doses. However, the resulting vaccine had only a 70% effective rate.

"The undiluted vaccine has about a 95% take rate," she tells *BW*. "It is not perfect, but we would like to be as close to that as we could be."

The new study will include a one to five dilution, which should show greater efficacy while increasing the stockpile to more than 75 million doses.

"We are looking at a 'take' rate for the vaccine, in other words how many people actually develop a typical lesion and whether they have a strong neutralizing antibody response to the vaccine," Frey says. "We know that the vaccine is still good. We actually titered the vaccine and it is very similar to its original titer," she adds. ■