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Changes to HIPAA privacy rule should ease case managers' burden

CMs are among those 'most affected' by changes

In what may be good news for case managers, the Department of Health and Human Services (HHS) published a proposed regulation March 21 that, when final, will amend the existing privacy regulations under the Health Insurance Portability and Accountability Act (HIPAA). Health care attorneys say the resulting changes could ease the administrative burden on case managers.

"I think case managers are going to be one of the groups of people most affected by these changes," says **Rebecca Williams**, JD, a health care attorney for the law firm Davis Wright Tremaine in Seattle. Under the current regulation, case managers are able to contact home health, skilled nursing facilities, and others on behalf of patients about to be discharged because it is for treatment purposes. The problem is that the entity receiving the call is unable to use protected health information (PHI) until it has the patient's consent.

"It is ludicrous," asserts Williams, who co-chairs Davis Wright's HIPAA practice group. The wording of the current privacy rule threatens to interfere with continuity of care, she says. For case managers attempting to make arrangements on the patient's behalf, that spells major headaches. Fortunately, HHS recognized this unintended consequence and is attempting to fix that problem in the proposed regulations, Williams says.

The proposed rule would allow, but not require, covered providers to obtain advance consent for treatment, payment, and operations. Instead, covered providers will need to provide their notice of privacy practices to individuals on the first date of service and make a good-faith attempt to obtain the patient's acknowledgement. This approach is less likely to interfere with treatment and continuity of care, she says.

Additionally, the proposed rule clarifies how a covered entity may disclose PHI for treatment, payment, and operations. "One very important

thing for case managers is to understand that this proposed rule, and ultimately the final amendment, are going to be very important for them. It will change how they currently function," Williams says.

The second thing case managers should realize is that the privacy rule will be effective in less than a year: April 2003. When Congress passed an extension for the transaction and code set portions of HIPAA earlier this year, it emphasized that there will be no delay for implementation of the privacy regulation.

Williams says it also is important for case managers to become accustomed to the limits on how they will use and disclose PHI.

Crane Pomerantz, JD, health care attorney with Morgan Lewis in Washington, DC, takes a similar view. "My sense is that the biggest risk is going to come in the form of inadvertent disclosures," he says. The provision in the regulation that addresses intentional disclosures for financial gain is likely to be the exception rather then the rule, Pomerantz explains. Conversations in elevators and disclosure of PHI to contractors without adequate assurances in a business associate agreement are likely to be the type of violations more frequently cited, he predicts.

Flexible though challenging

While the privacy regulations no doubt will be challenging for case managers, the privacy standards are written with considerable flexibility, Pomerantz says. That is particularly true in the area of safeguards, where the regulations say only that appropriate administrative, technical, and physical standards must be implemented. "'Appropriate' does not seem like a very exacting standard," he says.

Pomerantz points to a simple example included in the preamble: If patient files are stored in an office, the door should be locked and the number of keys that are distributed should be limited. "It seems to me that HHS is taking a very flexible functional approach to how these rules should be implemented." Likewise, the standard for policies and procedures says they should be reasonably designed to ensure compliance. "That does not sound like a terribly exacting standard to meet, and it suggests to me that there is a significant degree of understanding and reasonableness from the government," Pomerantz adds.

There still are likely to be some confusing days ahead, Williams warns. "It is possible that HHS will make a few more changes to the proposed regulations before they become final, and that will impact the final regulation."

It also is important for case managers not to overstate the potential impact the privacy regulation will have on their day-to-day activities, says **Patrice Spath**, BA, RHIT, president of Brown-Spath & Associates, a health care quality consulting firm based in Forest Grove, OR.

"The privacy regulations create new liabilities, but they do not create new responsibilities. I don't think the original regulation was going to significantly threaten what hospital case managers were already doing," explains Spath, who recently spoke on HIPAA privacy issues at the 7th Annual Hospital Case Management Conference in Atlanta.

CMs responsible to guard patient's privacy

Even if the privacy regulations did not exist, case managers still would have responsibilities in this area. "Regardless of how these regulations are finalized, the bottom line is that it is our duty to protect the patient's privacy and make every reasonable effort to do that," Spath says. Likewise, there are state requirements, which often are more stringent than the proposed federal requirements.

According to Spath, the privacy regulation is more threatening to independent case managers and those who work for disease management firms because they often are the recipients of information that they cannot act on until they have patient consent. The hospital case manager, on the other hand, is essentially going to be covered by the consent form the patients sign when they come into the hospital. "There is already a process established for anything related to treatment or business practices and operations."

For example, if a case manager orders durable

medical equipment (DME) for a patient, the DME company would be responsible for obtaining appropriate consents prior to using protected information for any treatment, business, or operations purposes, Spath says.

Further, if a patient is transferred to another hospital, that hospital has not yet started treating the patient, so that hospital can obtain consent when the patient is transferred, she explains.

One exception may be the area of marketing, which actually is strengthened under the proposed changes. For example, case managers may be viewed as "marketers" when they share information with patients about support groups or other services sponsored by pharmaceutical companies, insurance companies, or other vendors.

Leigh-Ann Patterson, JD, a partner with Nixon Peabody in Boston, says the proposed regulation would tighten the restrictions on health-related marketing activities.

The current rule allows private health care information to be used for marketing purposes without prior patient authorization as long as the solicitation or promotional materials contain certain disclosures and opt-out provisions, Patterson says.

The proposed change closes this loophole by requiring prior patient authorization before any protected health care information may be used for marketing purposes, which means permission-based marketing programs will no longer be the exception but the rule, she adds.

"What's the bottom line? Case managers, as well as all health care professionals, must constantly reinforce the importance of patient privacy during the provision of services," Spath says.

"Case managers should get to know their institution's privacy officer. This person is knowledgeable about state and federal regulations and is an excellent resource for case management-related questions," she points out.

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Innovative methods help case managers cut stress

'Team management' helps CMs share the load

One of the major reasons for the growing critical shortage of nurses is the stress that goes along with the profession. Case managers, many of whom are trained nurses responsible for nursing services, face a high rate of turnover and "burnout" as well.

"The problem is that case managers are in a job that can be called a 'fire station,'" says **Linda Arnold**, RN, a motivational expert based in Brunswick, ME.

"If there are a number of calls that come in, you have to handle them." What case managers can do is look at how they organize themselves and keep the level of stress to a minimum, says Arnold, who also is a trained psychiatric nurse.

Kathleen Lambert, JD, RN, who has been a practicing nurse for 31 years and a health care lawyer for 10, says that one of the biggest challenges facing case managers is the number of tasks they are required to perform.

Using the team concept

"Case managers are in a continuous multitasking situation," says Lambert, who spoke on legal issues affecting case managers at the 7th Annual Hospital Case Management Conference, held recently in Atlanta. One technique that she found very helpful when her patient care load got very heavy was to "team manage" with another nurse whose skills and temperament were similar to her own.

"Rather than try to carry the whole load by myself, there would be certain cases that I would team-manage with another nurse," she explains. In many instances, these were the more complex cases that required more insight in terms of what was needed for the patient.

"This gives the patients the advantage of having more than one person looking at their needs in that particular situation."

This technique also helps to protect the patient, Lambert adds. "If you get tied up with another issue for another patient, the other case did not get away from you to where you could barely catch up to it or put the patient at risk. It is an effective way of managing it, and it is very collegial."

Once a team approach is established with one patient, it's easy to use the same approach with another patient, she adds. "The rhythm is already there."

Anne Llewellyn, RNC, BHSA, CCM, CRRN, CEAC, co-founder of Professional Resources In Management Education in Miramar, FL, says that working in a team with another case manager is especially effective if it is focused on mentoring and the value and resources that each case manager brings to the process.

"We cannot do this job in silos," she explains. "Working together with other case managers streamlines the process and decreases the fragmentation that occurs so often."

Get organized

Another technique Lambert recommends is "calendaring," which she learned as an attorney. Attorneys often work a case backward by starting with an end date and then "calendaring" what must be accomplished at certain points along the way. "You work backward to the date where you are today," she says. "That gives structure as to what needs to be done on what case."

Ellen Mitchell, MA, RNC, a case manager at Saint Vincents Hospital and Medical Center in New York City, says that she uses a similar technique involving multidisciplinary action plans (MAPs) based on diagnoses. Mitchell says when she begins her day, she looks at the census for her unit and writes lists about what those patients require that day.

"I look at it going forward on a day-to-day basis," she says. "It is almost like having your own list of things to accomplish. I call that my 'to-do' list. That is how I organize my day."

Llewellyn stresses that an important part of the case management process is organization. "If case managers are not organized, they will not be able to handle their caseloads effectively and they will burn out," she warns. "Calendaring or some type of a diary system is very effective."

While there are many tools that make this task possible, case managers often have their plans interrupted by unexpected events, Llewellyn says. "Being flexible allows us to adjust our day to meet these unexpected events."

Knowing when to say no and when to ask for help is also important, she says. "If you work in an organization where there are other case managers, make sure that sharing resources and offering help is part of the culture of your case management department," Llewellyn adds.

Two important principles are to accomplish a little bit all the time, and never to let anything overwhelm you, Lambert adds. "If you just bite off a little bit at a time, it is doable. That is basically what calendaring is. It says, 'Here is your case; here is the endpoint. Do these little pieces along the way, and you will reach your goal.'"

According to Arnold, common-sense techniques that apply to many other professions also apply to case managers.

Case managers should understand how they react to certain situations — what she calls their "existing points of view" — and learn how to let go of the ones that are not helpful. By prioritizing and doing what is in front of them, nurses will preserve their resources, she explains.

"Nurses have a tendency to get caught up in shoulds. Sometimes, [nurses] are right that things should not be the way they are, but if that is the way they are, you use a lot of energy and cause a lot of stress by saying they should not be," Arnold says.

Some things are out of your control

Case managers also must understand what is within their control and beyond their control, she adds. "There is a difference between 'control' and 'impact. We can all have impact by talking to the manager, but we don't have any way to say, 'Do it my way.'"

"This is definitely something that nurses struggle with," Arnold says. When conflicts arise, it is useful to put it in behavioral terms rather than personalizing the situation, she says.

Seeking out continuing education is another challenge because many case management-related conferences require travel and a few days out of the hospital, Mitchell notes.

She says it often is difficult to find the time and resources to attend those meetings. "The opportunities are there, but in a large case management department, not everybody can do that."

Mitchell says she has taken advantage of many on-line educational programs.

For example, she says the New York State Nurses Association in Latham has a useful catalogue of continuing education opportunities on-line (www.nysna.org). While they are not always specific to case managers, they do address clinical issues.

"That is where we extrapolate most of our information," she says. "Keeping current with

what is going on in the clinical mainstream helps us develop the plans that we require."

Finding ways to combat stress

According to Llewellyn, case managers often fail to take time to care for themselves. "To avoid burnout and prevent illness, it is very important to look at ways that allow you to 'de-stress,'" she says. "Exercise, mediation, yoga, and forms of relaxation are all popular ways that you can begin to take care of yourself."

Recognizing stress and taking time out to reduce stress need to be incorporated as part of a case manager's daily routine, Llewellyn says. It is also important for case managers to know their limits, she adds. "Many times, we as case managers feel we need be there for everyone, and we tend to forget about ourselves. Taking care of yourself allows you to be more effective for others in both your personal and professional life."

Lambert says she has known many nurses as well as lawyers who have become burned out because they focused solely on work. "If you do anything to an extreme, your brain will tell you not to do it anymore, and your body then will start to react and arrange it so that you can't do it anymore."

"I am a firm believer that everybody should have a hobby so that you can walk away and go home and not focus on the job," Mitchell says. Case management is both a very interesting and a very difficult job, she adds. It simply is not productive to think about it 24 hours a day.

Lambert says case managers should take a holistic approach to both their life and their profession. "We are going to take on a lot of stress in a helping profession like case management. You can't be near the fire without feeling the heat."

Lambert says that, for her, that meant developing structure in all areas of her life in order to do everything she enjoyed while maintaining enthusiasm for her profession. She started that process by listing her priorities, including her husband and four children.

Case managers who ignore the signs of stress may insulate themselves from the discomfort they are experiencing, Lambert warns. In some cases, that can lead to drug or alcohol abuse. In other cases, it may lead to procrastination. "Sometimes people will procrastinate to the point of being fired. It is a subconscious sabotage."

"Exercise is critical," Lambert says. But other tools also can help reduce stress, she adds. That might mean finding a certain kind of music that is relaxing while not intrusive to co-workers.

Massage can be another effective technique to reduce stress. "I think everyone should plan that in his or her routine at least once a month," she says. "It is amazing the energy it will give you."

Finally, case managers should not neglect their spiritual life, Lambert says. "One of the most important things in my life is my spiritual life, and I think when you neglect that, you lose a wonderful means of dealing with stress." Case managers who find a way to develop that area of their life will have another important resource to draw on during difficult times, she says.

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GAP program improves patients' quality of care

CMs critical to the process

Following evidence-based practice guidelines and standardized treatment protocols can significantly improve the quality of care of patients being treated for a heart attack, according to the results of a recent study performed under the auspices of the American College of Cardiology Foundation's (ACCF) Guidelines Applied in Practice (GAP) initiative.

Kim Eagle, MD, chief of clinical cardiology at the University of Michigan Health System in Ann Arbor and the study's principal investigator, says that many groups and academic divisions of cardiology have created effective partnerships with nurses and physician assistants who act as "care extenders" to ensure quality patient care in the management of acute myocardial infarction (MI).

He adds that case managers can be critical to this process by ensuring that the system is properly employed and key quality indicators are applied.

According to Eagle, all members of the team must have a comprehensive understanding of the priorities, and mechanisms must be in place to ensure they are followed.

"The GAP model really says that we need to make sure that all of the people involved in the care itself — the patient, the doctor, the nurses, and / or care extenders or case managers — are in agreement in terms of meeting certain priorities for care and documentation of that care," he explains.

The GAP tool kit includes:

- **pocket guideline**, an easy-to-use, condensed version of the ACC / *American Heart Association Practice Guidelines for the Management of Patients With Acute Myocardial Infarction*;
- **standard order sets**, which serve as a trigger for physicians to make decisions about proven therapeutic measures in heart attack patients and allow physicians to easily order and document appropriate care;
- **critical pathway for nurses**, which helps them track patients through the normally expected course of events during hospitalization;
- **materials for patients** to use after they leave the hospital that remind them about the importance of taking their medications, improving their diet, and other activities aimed at preventing future cardiovascular events.

Eagle says the pathway acts as a daily reminder of how and when various tasks must be performed on behalf of patients during their care. The role of nurses is especially important in that process, he says. For example:

- How does the team make sure all of the key steps take place on time?
- When does the patient move out of the coronary care unit?
- When does the dietary team see the patient and his or her family?
- When does the exercise physiologist provide the patient education about exercise?
- When does the smoking-cessation team help patients reinforce the discontinuation of smoking?
- Are patients receiving the right tests?
- Were the right medications added as discharge approached?
- Has the discharge document been examined to make sure that all the key items have been addressed?

According to Eagle, when the system is used correctly, the level of adherence to the targets of quality is exceptionally high.

"The case manager can be a very important person in terms of achieving those goals."

The GAP program addresses patient care from admission to discharge, he says. "We make sure we are addressing the key priorities and documenting when we have not — such as when we are not giving aspirin because the patients are allergic, or when we can't give a beta-blocker because they have active wheezing."

Effective quality assurance means providing evidence-based care and also documenting when the patient is not a candidate for evidence-based care due to some pre-existing conditions, he says.

According to Eagle, the tool kit helps ensure that the physician, nurse, and patient all are in agreement on the key priorities of care from admission to discharge and beyond. "When there is a system to remind all three of the key targets for care throughout the patient's stay, the level of adherence to these priorities improves, and patients get better care."

Another key ingredient is the use of standardized order sets and the use of a standardized discharge tool or contract. From the case manager's point of view, the combination of the tools, especially the standardized order and the discharge document, are essential to support a systematic process for moving the patient through the care that is delivered, says **Cecelia Montoye**, RN, MSN, CPHQ, co-principal investigator and GAP project manager.

Don't let patients fall through the cracks

Those tools will help caregivers focus on the most important areas of the guidelines, she explains. While case managers are depended upon to perform these functions for each patient, Montoye points out, they are not present 24 hours a day every day of the week.

"Some patients will slip through the cracks, and the standardized order and discharge document can help other staff members make sure that all of those important aspects of care are provided," she says.

According to Montoye, the tools can be modified by hospitals for their own situation according to the care they provide.

"The discharge document can help make sure the patients are ready to go home and receiving the care they need after they go home. That is something that a case manager often has to backtrack on after the patient has left," she says.

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CRITICAL PATH NETWORK™

Demand management helps reduce diverts

Best practices diffused across the system

A demand management program created at Overlook Hospital in Summit, NJ, has successfully reduced diverts, thus leading to an 89% staff retention rate.

The program has been implemented across the four-hospital Atlantic Health System, of which Overlook is a member.

"While everyone else was going on divert, our last full divert was Feb. 4th, but before that, we had gone 761 days without a divert," reports **Linda Kosnik,** RN, MSN CSCEN, chief nursing officer. In addition, the average admission cycle time was reduced from 129 minutes in April 2001 to 78 minutes in October 2001.

ED was headed for a meltdown

The need for such a program was spurred by the extraordinarily long times for admission in the Overlook emergency department (ED), Kosnik recalls.

"We had recruitment and retention issues because we were holding patients in the ED," she explains.

"Our goal was to reduce divert and bypass, which I believe is a result of inpatient services meltdown. We determined to reduce waits and delays using a crew resource management (CRM) approach," Kosnik says.

CRM is a communication methodology focusing on team-centered decision-making systems, which was developed by the aviation industry, she explains.

The concept originated in 1979, in response to a National Aeronautics and Space Administration workshop that examined the role that human error plays in air crashes.

When CRM is applied to health care, the communication dynamic of health care practitioners caring for critically ill patients can be viewed as resembling that of an aircrew engaged in complex flight operations. Use of team-centered decision-making systems enables teams to perform more efficiently.

Major goals established

As well as those goals, Kosnik and her team set forth these additional targets:

- Drive the diffusion of best practices.
- Decrease variation.
- Create a safe environment for patients and staff.
- Improve customer satisfaction.
- Improve communication.
- Apply an integrated approach to resource management.

This latter goal was virtually assured by the size and diversity of the team. In addition to such obvious members as the ED and inpatient and outpatient services, it included 22 support services, Kosnik says.

"These are frequently overlooked, yet they are probably the most important," she notes. "They don't realize how much they impact on the ability of patients to move through the system."

The best way to illustrate this, she says, is to imagine a single patient in the hospital, whose physician is waiting for labs to discharge him.

"If the labs are not ready, discharge is deferred until the doctor has another time [to] review them," Kosnik explains.

"That can be almost a day. An individual who could be discharged continues to occupy a bed,

and that starts to snowball. People in the lab had no idea that was happening," she says.

The team members gained greater understanding of their interdependence as the process unfolded, in part because of the structure itself. The program used color-coded "states" to illustrate the status of a given department or service. Green indicated a good day, based on criteria and interventions for that system. Yellow, orange, and red represented progressively less-desirable states.

"We initially identified what was perceived as a good day in terms of such issues as budgeted capacity," Kosnik explains. "The team added things in. For example, although respiratory therapy is budgeted for 100 [interventions] a day, the team realized that if they had 100 a day, staff might have to be cancelled."

The interventions were determined by the respective departments. "No one else could tell them what the early triggers, good days, and interventions are," Kosnik says.

Since this process was conducted systemwide, it also allowed a sharing of best practices. "The team members might have been doing certain things for years, but they had not told anyone," she notes.

An intertwined web

In the team structure, every service or unit has a partner, and they are the ones responsible for seeing that the unit is in green, Kosnik explains. So, for example, environmental was partnered with dietary because it was found that dietary would be brought back to green if someone else picked up the dirty trays.

"If they were 10 minutes late with one tray delivery, by the end of the day, that delay was compounded," Kosnik says.

"It was a satisfaction issue. People who came to visit patients were affected, and people were discharged who were still struggling to keep their meal down. Dietary had no idea of its impact on the way the system moved," she adds.

A hospital or a system is an intertwined web, Kosnik continues.

"It's always one system that goes down first," she explains. "The first thing that occurs, you intervene. For example, in the neuro unit, one of the biggest triggers is feeders. They don't have adequate staff. Their partner is respiratory, which is located right next to them.

"If neurology identifies themselves as being in yellow because of feedings, respiratory will send a tech in for a couple of hours."

Kosnik says she views a hospital or system as a metaphor for the human body. For example, if the liver is not doing what it is supposed to do, it will compromise other organs.

"But other organs will try to take over," she points out. In the hospital model, patient transport often fails first. Therefore, the numbers for their green and yellow states are much lower than they are for other departments.

Prevent problems from snowballing

"If you can't get patients to services, everything starts to snowball," Kosnik explains.

That's why it's important to have automatic interventions built into the system. "The closer you get to red, the more interventions you need to get back to green," she observes.

"You need more resources. So you must make every effort not to get there. And that, in turn, creates a lot of collaboration between units," which, quite naturally, enhances communication and cooperation. "It's real hard being angry with someone who you depend on," Kosnik says.

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An inside look at the Overlook process

Color-coding criteria and interventions

One of the focal points of the demand management process at Overlook Hospital in Summit, NJ, is a color-coded series of tables laying out green, yellow, orange, and red "states" for each of a number of departments/services and criteria and interventions for each.

These criteria and interventions are further divided into zone keys: C (Census), A (Acuity), S (Staffing), and O (Others).

A closer look at the emergency department (ED) shows how the process unfolds from state to state under C:

In the green state are the following criteria:
- < 100% ED occupancy
- Admission cycle times < 2 hours
- Critical care beds available (> 2)

In the yellow state, the criteria are as follows:
- > 30 patients in the ED
- Average admission cycle time > 2 < 4 hours
- < 2 critical care beds available
- Critical care holds > 1 hour

In the orange state, the criteria are:
- > 40 patients in the ED
- Average admission cycle time > 4 < 8 hours
- One critical care bed available
- Critical care holds > 2 hours

Finally, the red criteria are:
- > 50 patients in the ED
- Average admission cycle time > 8 hours
- No critical care beds available
- Critical care holds > 4 hours

Interventions progress in a similar fashion. For example, the seven interventions in the yellow state include having dietary pass out and collect meal trays and the initiation of bed status team meetings.

For orange, there are 12 additional interventions, including chief nursing officer opening additional beds and swing units if feasible, and additional volunteers assigned to ED.

In red, there are nine "red-only" initiatives, including having security round every hour and going to bypass / divert status. ■

On-line tool kit makes PI meetings obsolete

Sharing ideas through chatroom discussions

When Los Angeles-based Medical Management Planning's (MMP) benchmarking group of children's hospitals shares information, there always is something that strikes one or more members as worthy of further investigation and quality improvement efforts.

"In our quarterly benchmarking, some things are bound to jump out, whether it is a really great performer, or someone who just isn't there yet," explains MMP senior consultant **Sharon Lau**.

"We may target a couple areas, hold some meetings, and everyone has to travel so we can lay the ground work for investigation," she says. Six months of data collection and work to solve whatever problem is being investigated follows. It can be a slow process, and a costly one during a recession.

But the children's benchmarking group is about to try something completely different: an on-line program that uses a suite of performance improvement (PI) tool kits to help users work together at their leisure on a project without the need for travel. "We hope this will eliminate the travel and meetings we used to have to schedule," Lau says.

Holding meetings on the Internet

"We can do all the investigation with the on-line software, have people input their ideas, and then get everyone into one chatroom at a given time to discuss what we have found. Face-to-face contact is great, but there isn't any money," she says.

"We'd hate to have people not do investigations because they can't send someone to a meeting. This is a way to continue with the dialogue," Lau says.

The program, produced by the software company Skymark, is called Pathmaker. It already exists in a Windows format, but this is the first time the company is experimenting with an Internet-based product, says **Steve David**, the Pittsburgh-based company's president and CEO.

The program includes a variety of tools, including force field analyses that point out the influences that push someone toward a specific action, and that which discourage such action. Pathmaker also has voting modules, consensus analyses, and control charts.

"The control chart feature is really great," Lau says. "You can draw them right after you input information, too."

There is a brainstorming module that contains an affinity diagram tool for easy organization of ideas, she adds. There also is a cause-and-effect diagram that users have access to.

For the use of the beta version, each hospital in the group is paying $2,000 per year. "But that also gives them access to the same software for internal performance improvement projects," Lau explains.

The decision to use Pathmaker came after MMP considered developing its own software that would allow similar functions. "But one of our members had seen this," Lau says. "We called and have worked on this ever since."

A typical project might go something like this: A group wants to look at medication cost reduction, David says.

Each hospital working on the project can put its data on costs, distributors, and any other relevant information on-line to compare, he says. Then they brainstorm — on-line, either at the same time in a chatroom, or individually with a certain deadline date for input — on potential reasons for the high costs.

Put it to a vote

"They can put that into an affinity diagram or a cause-and-effect tree," David explains.

"This allows them to drill down to what the root causes might be, and what they can attack," David adds. Using the voting feature, members could vote on alternatives. Then the group tries the potential solution, collects information, posts it, and sees if it worked.

A demonstration project has started, and focus groups have begun using the program.

Among the first topics being studied are controlling the utilization of high-cost drugs, encouraging nonpunitive reporting of medication variances, and pain management in pediatric hospitals.

Lau contends that the benefits of the program will go beyond just saving money in the travel budget.

"When you are at a meeting, you only have the resources you can bring with you," she points out. "But when you are at your own site and working on-line, you have all the resources and information of the whole hospital on hand."

All the tools in one package

David says there aren't any programs out there — at least not Internet-based software packages — that provide all the tools necessary for a performance improvement project in one place.

"There are good brainstorming packages, good flowcharting packages, and other good tools. But they don't integrate it all in one place," he says.

"They don't solve the problem of getting things done fast, sharing information, and demonstrate their thinking process throughout," David emphasizes.

The program is platform- and browser-neutral, although it currently works better with Internet Explorer 5.0 or higher than it does with Netscape. It's not hard to learn, David says, and the system makes it possible for groups to collaborate more easily.

Saving on travel expenses

"Before, you had to fly people in from all over the country for a meeting," he says. "Work didn't get done between meetings, and if it did, it was hard to share results. With this, progress doesn't depend on everyone being in the same place. You can collapse the time and get better results sooner.

"[For example], you were going to do a project that was going to save your hospital a million dollars a year. If you can achieve those results this quarter rather than in the third quarter, that's a half a million dollars to your bottom line. Who's not interested in that?" David asks.

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*• **Steve David**, President and CEO, Skymark, 7300 Penn Ave., Pittsburgh, PA 15208. Telephone: (800) 826-7284.]* ■

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) 262-5521. Fax: (404) 262-5447. ■

AMBULATORY CARE
QUARTERLY

Outpatient managers face uncertain reimbursement

With the full impact of ambulatory payment classifications (APCs) still unknown for hospital outpatient surgery departments, ambulatory surgery centers (ASCs) are bracing themselves for an uncertain future.

"We don't know what they'll do to us," says **Lawrence Pinkner**, MD, immediate past president of the San Diego-based American Association of Ambulatory Surgery Centers and president of the SurgiCenter of Baltimore. "Maybe they'll link us to hospitals — not 100%, but maybe 95%." Or there could be a totally different fee schedule for ASCs, he says. "What we don't expect is a total increase in reimbursement. It's threatening. Nobody knows what will happen." If Medicare cuts rates, other insurers will follow suit, Pinkner predicts. "That could be death for lots of surgery centers."

Some surgery centers are closing because they found out they can't get reimbursed for pass-through items or disposable items. "We're working hard on third payers and say, 'If you pay us for disposables, we could do these procedures and save you a lot of money,'" he says. "Some are changing, but if it doesn't apply, it limits what can move to outpatient venue." If you make $100 to $200 for a procedure, you can't do them, Pinkner maintains.

Eric Zimmerman, JD, MBA, an attorney at McDermott, Will, & Emery in Washington, DC, is more optimistic in his outlook. He predicts that reimbursement for freestanding centers will change in the next three to five years, but it probably will be for the better.

"There no doubt will be some winners and losers; i.e., reimbursement will increase for some procedures and drop for others," Zimmerman says. "However, overall, changes on the horizon in Medicare reimbursement will improve stability and predictability in ASC service reimbursement and also an expansion in the number of services that will be covered in the ASC setting."

Pinkner describes reimbursement as the "single biggest burden on managers." However, with the help of tracking software, managers are becoming knowledgeable about their profits, he says. Software can even track the cost by physician, Pinkner says. Good managers will analyze their costs and know when to tell physicians they can't provide the procedure, he says.

Expect increased managed care contracting with outpatient surgery centers, predicts **Jennifer Marks**, MPH, acute care product manager at SMG Marketing in Chicago. "Low overhead and this consumer demand for outpatient services appeal to managed care organizations, and surgery centers themselves can offer multiple types of services to patients," Marks says. "It's a combination of it being less costly for managed care and consumers being happier with outpatient service rather than be admitted."

One thing won't change in the years ahead, Zimmerman predicts, and that is the dominance of Medicare. "As the Medicare population swells, so too will the role that Medicare plays in the ASCs, from reimbursement to influence on arrangements," he says.

While some surgery centers are converting to inpatient status, some hospitals are abandoning that niche and converting to all outpatient care. In 1999, 12 hospitals in the country were outpatient facilities, according to the Chicago-based American Hospital Association. That number grew to 22 in 2000, according to the association. A look at one facility that took this step provides some of the reasons.

Mercy Community Hospital in Havertown, PA, was a 64-bed medical/surgical hospital with a five operating room surgery center and pain center. "Recently, the market has been turbulent, particularly in that reimbursement was not keeping pace with costs," says **Martin McElroy**, hospital administrator. "Also, malpractice has escalated in this area, [and] with the nursing shortage, salaries were going up," The hospital couldn't survive with 64 inpatient beds when they were surrounded by large established institutions, including one from

their own health system within seven miles. Thus, the inpatient hospital services and the emergency department have ceased operation. An imaging center and an outpatient radiology area have been added. Sixty percent of the full-time employees are being placed elsewhere, and 25% will remain on campus, McElroy says. The remaining 20% have been terminated. Now the hospital is adjusting to being an outpatient facility.

"We hope to provide some things that the community is looking for now: state-of-the-art services in a manner that is customer-friendly," he says. "We want to reduce waiting times and focus the specific needs of outpatients."

One of the biggest challenges has been changing the culture to focus more on patients and physicians, he says. "From inpatient to outpatient, the challenge is: What is the level of care you're able to give? Is it customer-friendly to the point at which people feel there's value added to that?"

Expect more hospitals to follow Mercy's lead, McElroy predicts. "As you look to the future, the things that keep coming up . . . are the ability to serve the patient and physician in a new health care model that has easier access, more timely services being provided, and also the ability to get the turnaround time that patients are demanding. Those types of things, if we can address them, will help us become successful."

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*• **Martin McElroy**, Hospital Administrator, Mercy Community Hospital Center, 2000 Old West Chester Pike, Havertown, PA 19083. Telephone: (610) 853-7001. Fax: (610) 449-0415.]* ■

Question: I'm confused about the new policy statement from the Baltimore-based Centers for Medicare & Medicaid Services (CMS), which implies that disaster plans for transferring patients will supercede the Emergency Medical Treatment and Labor Act (EMTALA). My question is: whose definition of a disaster? Many hospitals these days use a modified disaster plan when the hospital or the emergency department (ED) is overloaded. For small hospitals, a handful of patients may activate the disaster response. For others it may be 10, 20, or 30 patients. Who decides what definition is used?

Answer: According to **Stephen Frew**, JD, risk management consultant at Physicians Insurance Company of Wisconsin, based in Loves Park, IL, the CMS policy statement has resulted in significant confusion. "The reader's point is well taken and reflects my own concerns with the policy statement. I do not believe that it affirmatively grants any dispensations." Frew gives this summation of the CMS statement: Based on a community disaster plan, under some circumstances, it may be permissible to refer patients away to a central bioclearance location. "That is a long way from saying that EMTALA does not apply to disasters," he says. The CMS will determine whether a situation is a disaster, probably on a case-by-case basis, he adds. "They will probably look at the formal community disaster plan, because that is the only one mentioned in the release." The statement does not address issues of documentation, transfer procedures, medical screening standards, advance acceptance, duty to accept, or any other EMTALA specific issues, and does not apply to any situation other than bioterrorism, Frew explains. "At best, if there is a communitywide disaster plan, the hospital may be at less risk of EMTALA violations if [it is] operating under that plan. It is by no means an assurance."

Question: A computed tomography (CT) scan or other specialized examination is often necessary for patients at our satellite ED, which is 25 miles from our main campus, to determine if an emergency medical condition exists.

These patients come by ambulance to the main campus to have this testing done. Must the patient be transferred over only for the specialized exam, and then officially transferred to the ED only if there are positive findings?

Answer: According to Frew, if you provide necessary pre-transfer evaluation and stabilization within your capability, and the main campus is willing to accept the patient, then with proper EMTALA documentation, you can transfer the patient to the main campus, rather than just transferring the patient for testing. "With a 25-mile drive and limited resources back at the rural facility, this seems in the best interest of the patient," he says.

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(Continued from page 86)

The results of the program were significant, according to ACCF. For example, before implementation of the ACCF-GAP program, only 65% of heart attack patients received beta-blockers within 24 hours of arriving at the hospital. That figure rose to 74%. Similarly, the percentage of patients receiving aspirin within 24 hours of admittance rose from 81% to 87%, and the percentage of patients who were prescribed aspirin on discharge from the hospital rose from 82% to 92%.

These changes mean fewer people will die from their heart disease, Eagle says. Use of beta-blockers in patients admitted for a heart attack has been shown to reduce the risk of death one year after discharge by 20% to 25%. Similarly, use of aspirin in heart attack patients at admission and at discharge can reduce the risk of future heart attacks by a similar percentage.

Smoking-cessation counseling, which improved from 53% to 65%, is particularly important because studies have shown that quitting smoking can reduce the risk of a second heart attack and heart disease-related death by 50% or more.

"The GAP project provided for greater consistency of care regardless of age or gender, and closed the gap of care that existed for the elderly and female patients in several areas of care," Eagle says. "For patients, this means an improved quality of care while they are in the hospital and improved outcomes after discharge," he adds.

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The GAP tools for heart attack treatment may be downloaded at no cost from www.acc.org/gap/mi/ami_gap.htm.] ■

GUEST COLUMN

How to sample case management performance

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

When evaluating the quality of services provided by case managers, it is not necessary to review every medical record or survey every patient. The total time involved in gathering data will be much less if you are using sampling to study the population. Plus, there is a shorter time lag between data collection and reporting.

With a smaller number of observations, it is possible to provide results much faster as compared to reviewing 100% of the total population.

Through the careful application of sampling techniques, you can efficiently gather a sufficient amount of information to make valid judgments about the quality of case management performance. Sampling is the process by which inference is made to the whole by examining a part. There are several sampling techniques to choose from. You'll want to choose a method that ensures every patient in your study population has an equal chance of being chosen for study. For example: If there are a total of N patients in the population and you choose K of them to review, then each patient could have been chosen with a probability of K / N. Generally, you'll want to use a random sampling method. Random sampling ensures that the sample is representative, on the average, of the entire study population.

Types of samples

Suppose you want to construct a process measure for completeness of record documentation by case managers using random sampling rather than 100% review. If you choose to use a pure random sample, you would randomly select records from the entire population (all patients seen by a case manager) for the observation period. The selection of a random sample usually is made with the help of random numbers. For instance, suppose the case managers saw 500 inpatients last month and you want to review a sample of 25 records.

The patients are numbered from 1 to 500. Select 25 random numbers that fall between 1 and 500. Random numbers can be generated through any number of computer programs, including most database and statistical analysis packages. The records that correspond to the random numbers are the ones selected for your review.

The rate of compliance with documentation requirements would then be calculated as the

Sample Sizes for 90%, 95%, and 99% Confidence

Confidence Level
Standard Error of the Mean = 5%

Population	90%	95%	99%
25	24	24	25
50	43	45	46
75	60	64	68
100	74	80	86
200	116	133	156
300	144	168	206
400	163	197	251
500	177	213	267
750	201	255	354
1,000	215	279	401
1,500	231	307	462
2,000	241	323	500
2,500	247	334	527
3,000	251	342	548
4,000	256	351	572
5,000	259	358	588
7,500	264	366	612
10,000	266	371	625
15,000	268	376	638
20,000	270	378	645
50,000	272	382	658
100,000	273	384	662

Population: The total number of cases in the population under study. For example, the number of patients on Medicaid, the number of low birth weight babies, or the number of patient records.

Confidence Level: The percentage of possible population values captured in the sample size. For a 95% confidence level, you could be certain that your sample will include 95% of all the possible values.

Standard Error of the Mean: A measure of the average amount by which sample means deviate from the true or population mean.

number of records with complete case management documentation divided by the total number of records reviewed.

This estimated compliance rate would be a fair representation of the chance that the next patient record will have appropriate documentation. This is an example of a pure random sample leading to an estimated compliance rate.

You could measure the same process (complete documentation) by taking a stratified sample of cases. The record population could be stratified (or divided) into many different categories, but for simplicity we'll divide them into two "strata": records of patients 50 and older, and records of patients 49 and younger.

You'd then select your sample from each of these strata rather than the population as a whole using random sampling techniques. If you divide the population into several categories based on the case manager assigned to the patient, random sampling techniques would be applied to each category.

However, if you intend to compare rates of compliance among case managers, then larger sample sizes must be available in each stratum. It may be more practical to evaluate case managers as a group; otherwise, a large review effort will be required to ensure meaningful comparisons.

Sample size

Many researchers strive for a sample size that reflects a 95% confidence level. This should be your goal also. The confidence level measures the percentage of possible population values captured in the sample size.

At the 95% confidence level, you can be fairly certain that your sample will include 95% of all

the possible values. As expected, higher confidence levels require larger sample sizes.

If you wanted to be 100% confident that all values will be captured in your study, it would be necessary to sample the entire population. **(For a sample-size selection table that illustrates the confidence levels for samples from different size populations, see box, p. 94.)**

For example, suppose you want to be 95% confident that the sample of records you will review to determine case manager compliance with documentation requirement is representative of the entire population of records. You'd need to review 213 records of the total population of 500 records. The sample sizes are expected to yield a 5% error rate, meaning that the findings from your review of 213 records may be 5% higher or 5% lower than what actually is happening in all 500 records. Poorly designed data collection instruments and/or badly trained data abstractors will increase the standard error of the mean.

Selecting cases

There are two methods that can be used to select cases for your study population. One method requires that the population is already known (e.g., patients discharged last quarter). This is a retrospective method of sampling that can be used to identify study cases from a population of patients who already have received care. When the population of patients already is identified (e.g., all patients discharged last year), list their names or other identifiers from 1 to N. The order of the listing is irrelevant. Generate a random number from 1 to N; that number is applied to the list of patients, and the patient corresponding to the random number is "chosen" for the study. A second random number is generated; if it is the same as the first number, it is disregarded; if it is new, then it is used to identify the second patient chosen. This continues until the total number of patients selected for the study population is chosen.

The second method of sample selection is one that can be applied concurrently. For example, as patients are discharged, you can determine if data from their record should be gathered or if the case is not one that should be included in the study. When the population of patients is accruing as the sample is being drawn (e.g. all patients who will be discharged this quarter), the true size of the patient population is unknown. In this instance, the population usually is phrased in terms of percentage of patients whose records you wish to review. For example, assume that you wish to review records from 10% of the patients. Every time a patient appropriate for the study is identified, generate a random number between 0 and 100. If the random number is less than or equal to 10, then the patient is chosen for the study. If the random number is greater than 10, then the patient is not included in the study sample. When the next patient appropriate for the study is identified, a new random number is

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Editorial Questions

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

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generated, and the process is repeated. At the end of the study time period, approximately 10% of the patient population will have been chosen to be part of the study.

Gathering data on a sample of cases rather than 100% of the population is a reasonable choice for many of the performance studies conducted by case managers. The decision to sample is usually based on whether or not collecting data about every single member of the population would be too costly or take too much time.

Random sampling is the acceptable method for making sure that the study population is a representative subset of the total population. ■

CE questions

Please save your monthly issues with the CE questions in order to take the two semester tests in the June and December issues. A Scantron sheet will be inserted in those issues, but the questions will not be repeated.

21. When will the privacy portion of the Health Insurance Portability and Accountability Act regulations take effect?
    A. October 2002
    B. January 2003
    C. April 2003
    D. February 2005

22. Name the technique in which you "work a case backward" by starting with an end date, then listing what much be accomplished at certain points along the way.
    A. team management
    B. calendaring
    C. multidisciplinary action planning
    D. prioritizing

23. Which item is not included in the GAP tool kit?
    A. list of postacute care providers
    B. pocket guideline
    C. standard order sets
    D. critical pathway

24. To achieve a 95% confidence level, what size sample would be required for a population of 500 patient records?
    A. 116
    B. 168
    C. 177
    D. 213

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. ■