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Hospital uses scan form to integrate pathways and improve quality

Pathways focus on phases of care

Three years ago, Memorial Health University Medical Center, a teaching hospital in Savannah, GA, relied primarily on Joint Commission on Accreditation of Healthcare Organizations compliance requirements for its performance improvement priorities. "That was the low bar," says **Ray Perigard**, Memorial's management engineer. "We were shooting to meet the minimum standard requirements, and that was not going to get us to where we wanted to be."

As part of a major process improvement effort, the hospital decided to integrate all of its medical staff departments and their performance improvement efforts while at the same time integrating clinical and operational performance improvement into a single set of critical success measures based on outcomes.

According to Perigard, this does not mean that compliance is unimportant. Minimum standard requirements such as risk management, patient safety, physician credentialing, various Joint Commission requirements, corporate compliance, ethics, and medical records as well as other federally and locally mandated requirements for accreditation are still important, he says. "However, they are an adjunct to improvement," he says. "They are not the basis for improvement."

The aim of the clinical pathway program was to involve all functions at all levels, Perigard says. "It was not one person's job or one group's job," he says. "It was all functions involved in the care of the patient at all levels."

Memorial also wanted to integrate physician-driven improvements with its operational improvements. "We have trouble getting everything aligned," Perigard says. The aim was to shift the focus from department-level improvements that were not integrated or coordinated to improved clinical outcomes based on patient-focused improvements that ultimately would drive department-level improvements as well

as operational improvements, he says.

According to Perigard, one of the roadblocks Memorial faced was that it was focused on compliance. "Our performance improvement was focused on meeting the minimum standards, not improving care," he says. "All of our performance improvement activities were isolated individual departmental goals not necessarily supporting an overall direction."

At the time, each operational department had a performance improvement analyst who helped the department analyze what was taking place and develop performance improvement opportunities that fed into the quality management department, he says.

In addition, each clinical medical staff department had a performance improvement committee focused primarily on peer-review activities and morbidity and mortality analysis feeding back to the quality management department. However, there was no integration or communication between the two. "They functioned separately," he says.

According to Perigard, clinical outcomes information and collaborative teams were considered essential for improvement. "We needed to put groups of people together who were taking care of these patients and decide the best way to do that," he says. "We also had to have a way to communicate back to the physicians how they were doing."

One of the functions of his department is to issue physician profiles to all the physicians, Perigard says. Initially, those were limited to cost and length of stay because that was all the information the hospital possessed. For the most part, however, physicians did not respond well to information about cost, he says.

Instead, Memorial wanted to incorporate outcomes data. Unlike indicators of cost, when physicians learn that only 30% of their patients are walking on Day Three compared to 70% of patients for all the other physicians in the hospital, that immediately gets their attention, Perigard says. "We wanted to have a system that could collect the right information, feed it to the right people, and be used to improve the way we give care," he says.

Perigard's task was to develop a way to gather that information. In the past, Memorial relied on chart review, he says. By the time enough information was collected in a statistically significant format, however, the data were 9 months old.

"Half of the things we wanted to evaluate, there is no way to find in the chart," he says. "We needed a way to capture specific information and be able to use it as quickly as possible."

According to Perigard, the first objective was to create a system that was easy to use. "We could not create a system that was so cumbersome that none of the caregivers would want to even deal with it," he says. "We also had to integrate it with the current documentation system." Otherwise, there would be no compliance.

The system also had to be flexible, Perigard explains, because it included 500 patients, more than 500 DRGs, and numerous disease entities. "We had to be able to collect a broad range of information from a broad range of patients," he says.

Wanted: A comprehensive system

In addition, the system had to be comprehensive. "We did not want something that was only going to collect the 10 most important pieces of information," he says, with the next piece somewhere on the chart. "We wanted something that was going to collect everything we needed at the same time."

Finally, the system had to be automated. "Chart review just took too long," Perigard says. "We did not want something where we had a checklist that someone had to enter all the information," he reports.

That would mean hiring a full-time employee to sit in front on the computer all day and transcribe information into a database. "We felt that if we could automate as much of the process as possible, we could spend our time using the information rather than generating it," he explains.

Memorial also wanted to create a system that was compatible with the future of the hospital's

clinical information system, Perigard says. The hospital uses HBOC, and he knew that there were upgrades and changes coming, including a pathway program in just a few years. "We wanted something so that we would not have to reinvent the wheel when it came time to put in the pathway system" he says. "We wanted something that was immediately integrated."

Memorial implements scan forms

Memorial ultimately decided to use a scan form that came from a piece of software called TeleForm, Perigard says. **(For samples of scan forms and process improvement results, see *Critical Path Network,* pp. 119-121.)** The software designs a scan form and puts the information wherever the user wants to put it. "It is all-inclusive and does all the work for you in terms of processing the information," he says. "One of the reasons we chose it is that it has a completely flexible layout."

Many scanning software products are available, he notes. But some of them require the user to use *their* forms, he says. "They have pre-printed forms, and you type in the information," he says. "You are limited to their layout." Perigard says the cost of those forms would have totaled $50,000 a year.

Memorial also wanted a program that used standard paper, he says. "This system used standard copy paper right out of the box and could be set up landscape or portrait and could be photocopied." Master copies are maintained in the administration office, which is open 24 hours a day. "We have a wall with nothing but pathways on it," he says. "They keep a supply of all the pathways there."

The form was laid out with demographic information as well as dates and times and the patient's room number.

One side of the form has all of the desired outcomes selected for that day. In the center of the page is a simple choice between, "Met," "Unmet," or "Not Applicable," Perigard says. "That is all that the caregiver has to select," he explains. If the outcome was unmet, there is a space for comments where they explain why it was unmet. The back of the form is for nursing notes.

"This pathway and all of its pieces for that given disease entity become the interdisciplinary plan of care for the patient," Perigard says. "It is a permanent part of the medical record."

Perigard points to a sample from Memorial's open-heart surgery pathway. Each part of the pathway is set up with several different categories for outcomes such as progression, assessment evaluation, diagnostics, treatments, medications, diet, consults, and other case management concerns.

Some additional information, such as what tests have been done, also are included in order to track what is being monitored vs. the outcomes, Perigard reports.

"In this case, we are looking at how quickly the patient was excavated following surgery because we identified that as something critical to quick progression," he says.

The form also allows staff to view what type of antibiotics or pain medication the patient is on and then relate that back to whether the pain is controlled. "We can interrelate all the items on the page to each other," he says.

Karen Watts, RN, MSN, outcomes management specialist at Memorial, says the hospital used Care Maps prior to implementing clinical pathways. She says those large foldout sheets were really "task lists" that staff would have to copy every 24 or 48 hours. They mainly contained basic nursing information rather than best practice information.

"It was supposed to be multidisciplinary, but it was not," she reports. "It was just done because they needed a plan of care of some type."

Each of Memorial's current pathways is divided into critical time periods called "phases of care," Perigard says. Almost every inpatient pathway is one day per page. However, early in the stay, there may be one for pre-op, one for the operating room, and another for the recovery unit. "We divide it into those phases of care," he says.

For example, for stroke patients, there is one page for the first 30 minutes the patient is in the emergency department because so much is needed in the first 30 minutes, Perigard says. There is another page for the remainder of time spent in the emergency department. "It is very specific to the type of disease," he says.

The caregivers complete their pathway evaluation form for each designated day or phase, he explains. All pages stay together, are combined, and then are put in the medical record. Once the patient is discharged, the medical record goes to the medical record department. When the chart assemblers come across the pathway, they pull it out of the chart and put it on a copier, which is hooked into Memorial's local area network.

Instead of transferring that image to a piece of paper, it transfers the image through the network

to a computer in Perigard's department. TeleForm reads that image, pulls the data out of the image and immediately puts them into an ACCESS database, he says.

The TeleForm software processes and scans the database each night, and a data analyst verifies the data every morning.

Verifying the data takes about an hour a day, he says. "We process about 500 pages a day because there is one page per patient per day," he says. "It takes about an hour every day to make the corrections necessary to get the data in the database."

Within 24 hours of discharge, Perigard says, he has all of the outcomes required. "I can put out a report tomorrow on all the patients from yesterday and how their outcomes were met," he says. "That gives us the ability to look at the data on an ongoing basis."

Eventually, Memorial would like to have the data available live so that case managers can determine what the objectives were for their patients the day before, Perigard says. "We are not quite there yet."

Memorial has one database for each disease entity, such as a cardiac database and an orthopedic database. "At first, we had them all in one database," he reports. "The database was just too big and grew too quickly to manage."

Each form and field is uniquely identifiable, Perigard adds. Because of that, he can go back and interrelate pain medication to whether or not the pain outcomes were met on the same day or look at pain or ambulation across a continuum. By using the patient ID field, Perigard is able to look at the financial impact of meeting outcomes vs. not meeting outcomes, he points out.

Memorial now has 40 to 45 pathways, Watts reports. While she plans to develop a few more pathways, going much above that number will become unwieldy. The hospital also has generic pathways where it does not have case specific pathways.

Specifically, the hospital has a generic surgery and a generic medicine pathway for adults and for pediatrics, she points out.

Memorial also has two clinical programs and five collaborative teams that are part of the pathway. "I don't have teams for every pathway," she adds. "Some things I can do without a team."

Watts says she also avoids meetings for the sake of meeting. "I don't think much comes out of them," she contends.

Team meetings take place quarterly and are focused on data and potential actions, according to Watts. "There must be some action, or we are not going to meet," she says. When meetings do take place, they usually focus on high-volume, high-risk conditions that raise issues such as length of stay, cost, or outcomes, she adds.

Watts says she prefers a programmatic approach to employing pathways. Two examples of that are Memorial's stroke program and joint replacement program. Part of the latter program includes bringing patients in preoperatively to educate them about pain and mobility.

Performance improvement reports

Memorial also uses performance improvement reports that it issues to specific units. For example, units such as respiratory therapy, pharmacy, and other departments would receive a report on heart patients that included extubation times. The target was to have 75% of those patients extubated within four to six hours, Watts says. In December, roughly 54% reached that target. For the year, that number was 28%. "Obviously, we are making a lot of progress," she says.

Watts also correlates various indicators on the pathway. During the four weeks she spent implementing the pathway for coronary artery bypass graft and watching the progression of these patients, she saw that they were not ambulating enough and their diets were not progressing fast enough.

Watts says she found that you may have to alter the staffing model because the area where heart patients go is staffed only with RNs but no nursing assistants or others to walk these patients. Mobilization is tracked using a report on daily ambulation out of bed and daily ambulation in the hall.

"I want to make sure staff are steadily progressing their mobility their mobility, as an important indicator," she explains.

Another example Watts points to are cesarean patients. "We focused on C-section or vaginal deliveries because we have an extremely high length of stay," she says. One of the things her staff found is that pain was not managed consistently, and diet and ambulation suffered as a result, she reports.

To correct that, anesthesia was encouraged to prescribe Duramorph to help control pain, then pull the epidermal catheter, Watts says.

"That would hold the pain for six to 12 hours, and then they would start on a Toradol protocol

to control any breakthrough pains," she says. That improved alertness, diet, and ambulation, she reports.

While teams are much more interested in patient outcomes, Watts says her department also must focus on costs. There will be many competing priorities among departments, but when the results are there, it is difficult to argue against recommended changes in care, she adds. ■

Successful automation requires integrated effort

Involve physicians in selection of systems

Automation is an increasingly important component of effective case management programs. But **John Hinton**, DO, MPH, vice president of clinical information management at Catholic Healthcare Partners (CHP) in Cincinnati, warns that physicians, who often are not involved in the selection process of automated systems, must be part of the selection process if hospitals expect to achieve physician buy-in.

"The ability to check allergies and proper dosages helps us provide better care, reduces adverse outcomes, and helps prevent comorbidities," he explains. "As I work with physicians on computerized provider order entry [CPOE], those are some of the key features that I look for."

According to Hinton, it is not that the numbers are unimportant but rather that what is behind those numbers, including indications for potential interventions, is most critical.

"It is not just one provider, one nurse, one pharmacist that can influence the process," he explains. "It is the process of care delivery, the process of medication administration, and the process of diagnostic evaluation and treatment that we have to examine."

Barb Quick, RN, MS, CPHQ, CMAC, director of case management at Barnes Jewish Hospital in St. Louis, says that decisions regarding automation also must involve both the information systems and case management departments. "Successful implementation is the result of thorough planning," she asserts.

"We are highly automated," Quick says. "The only thing in our medical record that is not automated is physician order entry and history and physical." However, she notes that approval recently was granted for CPOE, which will be a four-year, $10 million project.

Quick reports that when the hospital implemented its automated case management system, it had a lot of the customization already completed, and that helped achieve buy-in for the new product among the staff.

"Many of our staff did not feel the need to be automated, and they did not want to be automated," she points out. "We had to do a lot of sales to them as far as getting them to use the product."

A team of people sat down and looked at each of the work processes, using a training module of the software product, Quick says. That required bringing in staff who perform particular functions, she says. For example, certification coordinators likely will have very different needs than the case coordinators and the appeals coordinators, she explains.

According to Quick, it also is important to understand how the current processes will be integrated with the new system.

During the six-month period when the interface was being developed, she says implementation was being planned. "By the time the interface was ready, we did some testing, and about a month later, we were ready to go live," she says.

Learning through trial and error

From a case management standpoint, Quick says there was no person dedicated to implementation. However, after some trial and error, the hospital eventually learned that was not sufficient. She notes that one smaller facility attempted to implement the new process using a staff-level person who was reluctant to upset her peers.

"Four years later, that hospital is still not totally automated," she reports. "They still have staff that don't use the system because they have never had a management team to insist they use the system and to sell the rationale behind that."

According to Quick, the hospital's information systems staff person spent two weeks in training classes with the vendor learning the system. "I don't think we would have been able to go live without it. That was extremely beneficial." That also eliminated the need to have the vendor on site, she adds.

Quick says it took considerable time and effort to convince information systems management that she needed someone who could manage the

system. She considered having a part-time RN manage the system on a full-time basis. However, she was convinced the information systems person had to be able to interface with his or her peers. "When changes are made to the upstream or downstream systems, somebody has to be there to test them," she explains. "We just don't know enough to do that."

The information systems person also is responsible for working on the interface errors, Quick says. Initially, there were roughly 50 errors a day, but that has been reduced to one or two a day, she says. The information systems person also will have to know how to change screens, she adds.

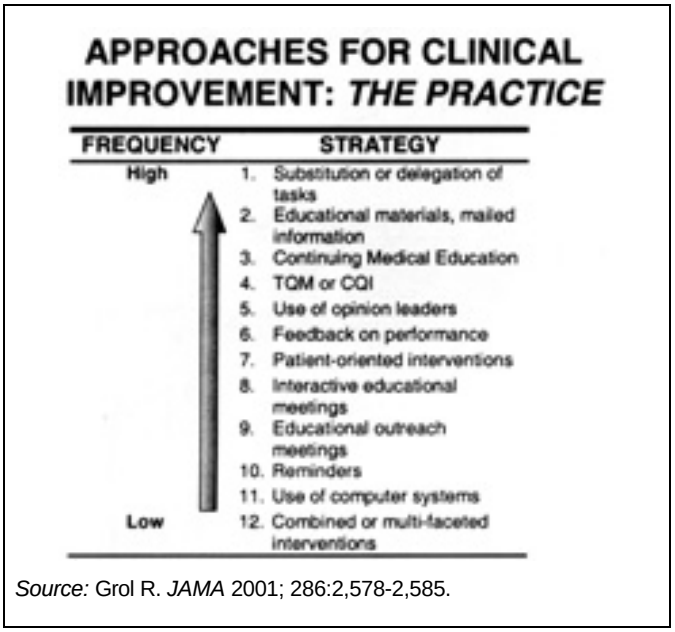
The product her department uses does not let users change any of their screens, but it does allow custom screens to be built. "We have really taken advantage of that," she says. ■

Engaging physicians is key to successful CM

Use lessons from peer review

Most professionals agree that the key to successful case management is learning how to influence physician behavior. But **John Hinton**, DO, MPH, vice president of clinical information management at Catholic Healthcare Partners (CHP) in Cincinnati, says how that is achieved often is very misunderstood.

Source: Grol R. *JAMA* 2001; 286:2,578-2,585.



Source: Grol R. *JAMA* 2001; 286:2,578-2,585.

According to Hinton, one critical area to which hospitals often fail to pay enough attention is peer review. "Peer review has gotten a bad reputation because often it is used only with problem doctors and not for routine surveillance of practice," he says.

One key component of peer review is that measurement of all physicians must take place consistently across standards, rates, and events, Hinton says. He contends that case managers and others should view that process as a "transformation."

By examining those three areas, he says, hospitals can view physicians' practices objectively and perform critical assessments. That examination should take place on an ongoing basis as opposed to when an exceptional event takes place, Hinton emphasizes.

"That way, we are not accused of witch hunts," he says.

Hinton says he sometimes uses blinded data when engaging physicians on performance measures and that doing so often provokes criticism of their own behavior. "Physicians are often surprised about the comments they made on their own patient care," he says. "Peer review does not have to be punitive," he underlines. "It can be educational and instructive."

Identify goals and objectives

According to Hinton, hospitals perform better when they have clearly identified goals, strong administrative support, and ongoing feedback.

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ACCESS MANAGEMENT
QUARTERLY

Proposed changes to EMTALA lack direction

Prior authorization, off-site locations addressed

Proposed changes to the Emergency Medical Treatment and Labor Act (EMTALA) regulations indicate an attempt to "clear up areas that get the loudest complaints," but still don't give providers the direction they need, says **Stephen Frew**, JD, a longtime specialist in EMTALA compliance.

"What people in the field really wanted is missing here," adds Frew, a web site publisher (www.medlaw.com) and risk management consultant for Physicians Insurance Co. of Wisconsin in Madison. In the proposed final rule, which would become effective in October after a comment period that ends July 8, the Centers for Medicare & Medicaid Services (CMS) "has tried to give examples and talk about the policies it expects to see, but still doesn't say what the policies are expected to contain, what they mean in practical terms."

While the proposed rule generally represents "some changes in what's in print, but not necessarily a lot in application," he says, there are some significant differences that should be of particular interest to access managers.

When it comes to issues regarding Medicare+ Choice plans, Frew says, the proposed rule reiterates that the patient must be stabilized before any calls can be placed for prior authorization and points out that a patient may need admission and surgery before he or she can be stabilized.

"So you have to go to the point of stability — a medical determination — before the call is made," he adds. "That basically leaves a situation where calls for prior authorization are hazardous. In the emergency department [ED], [providers] just can't do it."

EMTALA regulations have been enforced that way for 15 years, Frew says, but some hospitals have continued to interpret the stabilization requirement more loosely. "Because they are trying to make things more efficient, they've said, 'We're not delaying care; we're doing [authorization calls] simultaneously,'" he explains.

That's a problem, he says, "because of the implications of what a denial from the payer might do midstream. [CMS] is maintaining its position on that and emphasizing that [providers] have to call Medicare Choice and Plus plans [for authorization], but just like with all the rest of the payers, they have to wait until the patient is stable."

What the proposed change in the prior authorization section boils down to, adds **Linda Fotheringill**, a partner in the Towson, MD, law firm Siegel & Fotheringill, is that before a call can be made to an insurance company to obtain authorization, the medical screening exam must be completed as well as "any further medical examination and treatment that may be required to stabilize the emergency medical condition.

"So the point is, when is that 'magic moment' [when stabilization occurs]?" asks Fotheringill, whose firm specializes in health care issues and payer denials. "The proposed regulation is very unclear and subjective as to when a call could be made to the insurance company."

Fotheringill says she believes CMS recognizes that the provision is unclear, and that is why the agency is requesting additional comments as to whether it should be further revised. "They're asking whether the proposed regulation should be revised to state that the hospital may seek information from the insurance company and obtain authorization while providing stabilizing treatment — then they qualify that by saying 'apart from information about payment.'"

There is a discussion in the *Federal Register* about seeking comments on further changes that can be accessed by going to www.emtala.com, taking the direct link to the CMS comments on the proposed regulations, and looking at page 31,471, she points out.

"They're talking about adding language

[allowing] the hospital to call and get authorization so long as there is no delay in screening and stabilization services, but at the same time, they are prohibiting the hospital from obtaining information for payment," Fotheringill says. "Why would the hospital want to make what would amount to a meaningless call?"

Another confusing change under the prior-authorization section of the rule, she suggests, is that the proposed section states that for hospitals to be paid for post-stabilization care, they must notify the Medicare+Choice plan "promptly" after stabilization, but does not define "promptly."

But at the same time, Fotheringill points out, the proposed rule change says the hospital's attempts to obtain preapproval are to be consistent with another section of the rules.

"If the proposal goes through as is, it's setting up a situation where there will be more denials because the Medicare+Choice plans will be the ones making determinations as to whether the call was prompt," she adds. "As written, it appears that if the payer is not contacted 'promptly,' there will be few ways to overturn the denial that will undoubtedly occur. The bottom line is, I would suggest, that this section is limiting the hospital further."

250-yard rule

Another proposed change that is significant has to do with EMTALA's 250-yard rule, Frew says. "Previously, [the law] was set up to say that if a patient made it within the 250-yard zone or to hospital outpatient departments, he was covered by EMTALA."

The proposed change, he adds, is to limit that provision to hospital departments and off-site locations that are regularly used for unscheduled patient visits. CMS is asking for comments, Frew points out, on how to distinguish between a location that gets an occasional walk-in patient and one that is dealing with such patients enough to be held to the rules.

It is important for access managers to weigh in on this issue, he suggests, noting that comments will be accepted through July 8, 2002. "[CMS] is asking for a definition of 'significant portion of the time.'"

The proposal regarding the 250-yard rule indicates that CMS officials "are pulling in [EMTALA boundaries], but are not pulling in as far as it had been anticipated they might," he notes. Some members of Congress, Frew says, including EMTALA sponsor Rep. Pete Stark (D-CA), had said CMS "had gotten carried away with remote stuff."

Still, Frew says, the proposal limits the number of locations where EMTALA would directly apply. "It does still indicate that [personnel at these off-site locations] would be expected to do the best they can and call 911, but it lets them out of calling the ED, arranging for transport to the home hospital, and those kinds of issues."

The proposed rule goes on to say that if a patient presents in an area other than the ED with, for instance, a gash in the head, the receptionist is to summon aid, not send the patient somewhere else to get help, Frew says. "It also talks about allowing nurses in other situations to make the determination that the patient's condition isn't urgent and to send them elsewhere."

For example, he adds, if a patient previously had sutures and was told by the physician to come back to have them taken out, the nurse can assess the wound and send the patient to an outpatient clinic to have them removed.

"If the patient starts the visit as an outpatient on a scheduled basis, [the law] will assume for the course of events that the patient is not covered by EMTALA," Frew says. However, he adds, the proposal does give several examples. "If in the course of a visit, the patient should experience the sudden onset of a new condition — like having chest pain while blood is being drawn — then it is expected at that point the hospital will initiate EMTALA-type care."

Asked if that would not be an obvious course of action in a health care setting, Frew points out that in most such cases, hospital personnel call the patient's physician, who directs them to send the patient over for an assessment.

Another 'touchy' subject

Another EMTALA provision that is "a real touchy point" with hospitals has to do with policies regarding on-call physicians, he says. In the new proposal, CMS "reiterates that there is no hard-and-fast rule, but reserves the right to disagree with everything the hospital does."

"It depends on a lot of variables," Frew explains. "They are putting in writing that the hospital is free to decide how many physicians are on call in each specialty, but they will look at that and determine the capability of the hospital. It gets back to what they've always done in the past, which is second-guess the hospital."

CMS may have intended this change to be reassuring, he notes. "They are saying that it is not automatically a problem to allow senior physicians to be exempt from call, unless it compromises care."

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To comment on the proposed EMTALA changes, send an original and three copies to CMS, attention CMS-1203-p, P.O. Box 8010, Baltimore, MD 21244-1850.] ■

Read between the lines for 'ominous' message

Challenge likely on EMTALA inpatient stance

There is an "ominous" overtone and at least one glaring opportunity for court challenge in the proposed changes to the Emergency Medical Treatment and Labor Act (EMTALA) regulations, suggests **Stephen Frew**, JD, a longtime health care attorney and EMTALA expert.

"What's ominous is that even though EMTALA may not apply [in certain situations], the Medicare Conditions of Participation do," says Frew, a web site publisher and risk management consultant for Physicians Insurance Co. of Wisconsin in Madison.

In several instances in the proposed rule, he points out, the Center for Medicare & Medicaid Services (CMS) states that even if EMTALA doesn't apply, it has the right to look at a hospital's actions under the Conditions of Participation. Although the language may not seem significant to lay people or even health care providers, Frew notes, there is a between-the-lines meaning for those familiar with the law.

Don't miss the warning

"This says to me, 'We may let you off under the strict wording of EMTALA, but don't think that gets you out of everything,'" he says. "This is the regulator's way of saying, 'We're warning you. Don't think you can push the limit. We still expect reasonable conduct. If you push it, we'll nail you.'" The message, Frew adds, is that CMS is "loosening the chokehold, but still keeping hold of the throat."

When the proposed rule addresses EMTALA's application to inpatients, he continues, it opens itself up to "substantial court challenge," using logic that is "entirely contrary" to a long history of court decisions on the law's application.

The rule says that if a patient moves in and out of a stable condition, EMTALA applies, Frew notes.

But if a patient comes in for an elective procedure and becomes unstable while in the hospital — for example, has an embolism while having knee surgery — the patient would not be covered by EMTALA under the CMS interpretation, he adds.

The CMS interpretation is that the person in such a situation would be covered by the Conditions of Participation, he says. "The [hospital] still has to do what is medically necessary."

"A patient might have a problem, and Dr. So-and-so says he would rather deal with the problem at another facility," Frew adds. "Under EMTALA, [the hospital] couldn't move the patient unless it had to."

By holding such situations to the lesser standard of the Conditions of Participation, he suggests, "CMS is ignoring a major court ruling that interprets this differently. It doesn't matter which door the patient comes in, [according to that ruling] if the hospital is where the patient has an unstable condition, he is covered by EMTALA."

CMS will be challenged on this point, Frew predicts, "because those situations have resulted in lawsuits before."

Continuing lack of clarity

The proposed new regulations are written in the same "bureaucratic language that can be misinterpreted," Frew notes, which is his major criticism of the rule.

"Providers read the section that says it's up to the hospital how many physicians are on call, but then CMS says we can second-guess you," he says. "They're in the dark until they're nailed."

The new regulations represent an effort to put in writing the agency's general philosophy, Frew adds, "but philosophy doesn't help people with compliance."

More than 97% of respondents to a survey Frew did on his web site, www.medlaw.com, said they agreed with EMTALA, he notes, but

that they wanted "consistency, clarity, and a safe harbor" in regard to the law.

"They said, 'Give us the line in the sand so we know where we stand and then tell us if we do this, we don't have to worry,'" Frew adds.

The government has created safe harbors — "a set of rules that says if you follow these, we're not going to second-guess you" — for Medicare fraud and abuse, Frew points out. "If they can create fraud and abuse safe harbors, which are much more complicated, they should be able to do the same for EMTALA."

The difference, Frew says, is that CMS doesn't know how hospitals operate. "They're not familiar with how different hospitals function, what patient flow is, what referral flow is, so when they put in rules that cause problems, they are pretty much bewildered." ■

Interpreter service helps care quality, report says

Access to interpreter services — an area that often falls under the purview of access management — improves the quality of care and reduces the likelihood of medication errors, according to a recent survey examining language barriers in health care settings.

The report, released by the Boston-based Access Project, said 27% of those who needed but failed to get an interpreter said they didn't understand the instructions for taking their medications, compared with 2% who either got an interpreter or didn't need one.

Among those who reported needing help to pay for their medical care, 54% of those who needed but didn't get an interpreter said staff never asked if they needed financial assistance.

Among respondents who reported having unpaid bills or being in debt to the hospital where they received care, 40% of those who needed an interpreter but did not get one said they would not seek care at the facility in the future because of their debt, compared to 26% who needed and got an interpreter, the report states.

The federal government provides matching funds under Medicaid and the State Children's Health Insurance Program to pay for interpreter services, but only five states exercise that option, the report said. Those states are Hawaii, Maine, Minnesota, Utah, and Washington.

The Access Project is a program of the Center for Community Health Research and Action of the Heller School for Social Policy and Management at Brandeis University in Waltham, MA.

More information is available at the web site www.accessproject.org. ■

CE questions

5. The automated case management system at Memorial Health University Medical Center in Savannah, GA, includes how many DRGs?
   A. 85
   B. 150
   C. 375
   D. more than 500

6. At Barnes Jewish Hospital in St. Louis, approval was granted recently for a four-year $10 million project on what subject?
   A. improving clinical pathways
   B. computerized physician order entry
   C. HIPAA compliance
   D. EMTALA compliance

7. John Hinton, DO, MPH, vice president of clinical information management at Catholic Healthcare Partners in Cincinnati, recommends that hospitals periodically send physicians to spend a day in the office of a major payer to see firsthand how managed care operates.
   A. true
   B. false

8. The number of people who go on-line for information about health topics has grown from 54 million in 1998 to how many this year?
   A. 58 million
   B. 8 million
   C. 110 million
   D. 145 million

Answers: 5. D; 6. B; 7. A; 8. C

(Continued from page 118)

"You can't be vague on goals and roles," he warns. "Whether it is case management or whether it is physicians, you need to be very specific about what you expect to see."

For example, when Hinton tracked the use of beta-blockers in acute myocardial infarctions, he was able to differentiate the hospitals that were able to meet their targets from those that did not. The motivation for physicians to improve is not that beta blockers are not often prescribed, but that beta-blockers make a difference and dramatically improve patients' outcomes, he says.

Physicians' views often are "myopic," he warns. "They view their practice 'one patient at time,'" he explains. "Good performance information allows a physician to see how populations of his patients are treated."

Using evidence-based care

Hinton says he does not always favor the use of care paths, which some physicians still consider to be "cookbook medicine." Rather, the aim should be to focus on broadly accepted interventions.

"Then we must make sure those things are happening," he says. "That is not cookbook medicine. That is evidence-based care."

Once that is accomplished, the next step is to establish a physician advisor, and case managers should play a critical role in that selection, Hinton says. "Case managers must feel they have strong backup with a 'physician champion' behind them," he explains.

He emphasizes that the process must be very clinical, very pragmatic, and spearheaded by a physician. To help achieve that, Hinton sits down with physicians to help establish clear expectations. "You need to tell them what they need to be doing and how you want them to reform," he says. "You can't just expect that they know what to do." **(See graphs, p. 118.)**

According to Hinton, the American College of Physician Executives sponsors physician educational sessions that focus on working with physicians and improving quality. The American Board of Quality Assurance and Utilization Review of Physicians offers similar programs.

He also recommends that hospitals periodically send physicians to spend a day in the office of a major payer to see firsthand how managed care operates.

According to Hinton, messages and expected interventions must be integrated into physician practices. He says integration can occur by measuring utilization of evidenced-based practices, providing feedback to physicians and incorporating the messages in rounds, residency training, medical department meetings, and grand rounds.

"I try to make sure these messages get out and live within the organization," says Hinton. He says that means constantly getting them in front of the medical staff. "If you are tracking this

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Editorial Questions

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

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information through quality or medical and surgical committees, I think you must get the message out over and over again," he explains.

Interdisciplinary care teams

Hinton also has developed a video that explains how to work with interdisciplinary care teams. In his system, the interdisciplinary team assembles physician members from multiple disciplines to discuss a case and what is taking place unit by unit. "That has been highly effective," he reports. In fact, he says the interdisciplinary care team, along with performance feedback, use of physician champions, and quality oversight compose the primary success factors.

According to Hinton, physicians should run these meetings. He says that when he organizes a meeting, he acts as the external person to help ensure things run smoothly, but the physicians "own" the meeting. "That is key to moving things forward," he says. "Our job is mainly to facilitate."

Including board members on those committees also is very helpful because it makes the process more transparent, Hinton says. Including participants who are nonclinical helps enforce some accountability. But he cautions that often certain physicians are overused. "So often, we burn our doctors out," he says.

Hinton says another common mistake is to focus attention only on what might happen if something *is* done and to lose sight of what might happen if something is *not* done. "Many times, we are too worried that if we do something, something bad will happen, instead of what might happen if we do nothing," he says.

According to Hinton, the key ingredient throughout this process is collaboration, with a continued focus on quality outcomes for the patient. Often, he says, physicians will be inclined to function autonomously. "Effective feedback is critical," he asserts.

Hinton also reiterates that improved quality will result largely from effective tracking and trending performance. "A lot of that is how to understand data and process," he concludes. "Physicians are not big process people."

Finally, he says, hospitals must be sure to praise success and shine some light on the areas that are working. "We often tend to focus on the poor performers," he says. "We can learn from poor performers, but we can also learn from those who are successful." ■

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. ■

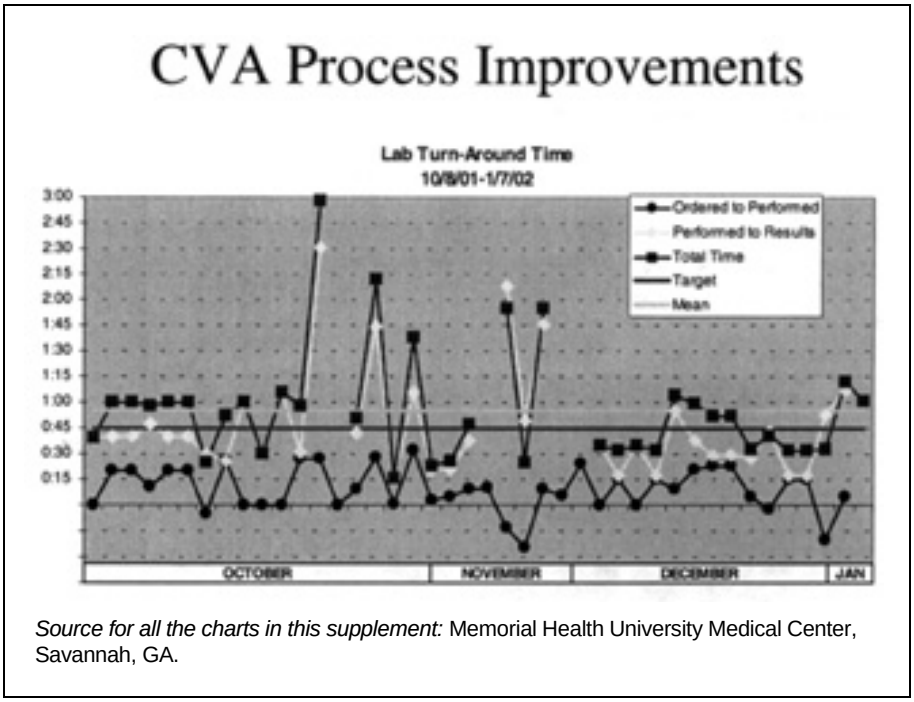
CRITICAL PATH NETWORK™

GA hospital uses scan forms for CVA clinical pathway

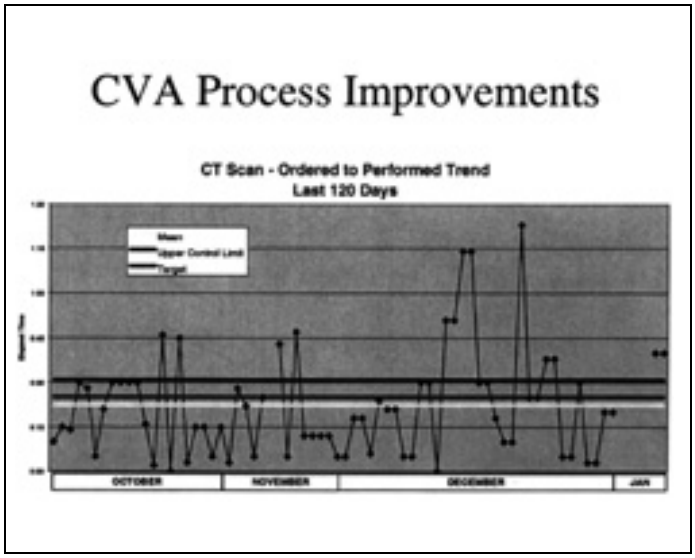
The following examples **(see this page and pp. 120-121)** are process improvement results and scan forms regarding the CVA (Ischemic or ICH DRG 14) clinical pathway at Memorial Health University Medical Center, a teaching hospital in Savannah, GA. **(For more on the process improvement, see related article, in the main issue, p. 113.)**

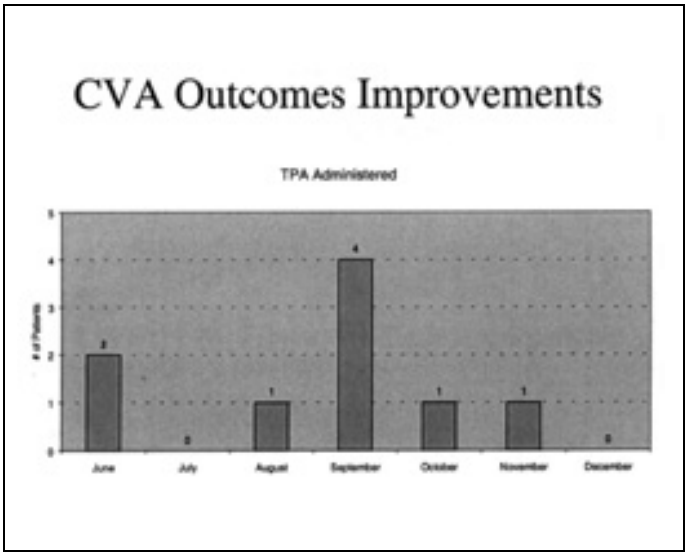
[Editor's note: Hospital Case Management *welcomes guest columns about clinical pathway development and use. Send your articles submissions to:*

• *Russ Underwood, Managing Editor,* Hospital Case Management, *P.O. Box 740056, Atlanta, GA 30374. Telephone: (404) 262-5521.]* ■



Source for all the charts in this supplement: Memorial Health University Medical Center, Savannah, GA.





Memorial Health University Medical Center

Clinical Pathway: **CVA (Ischemic or ICH DRG 14)**

Anticipated LOS: 5.0 **Days**

Date: ☐☐/☐☐/☐☐

Patient Identification ☐☐☐☐☐☐☐☐☐☐

Time Initiated: ☐☐:☐☐

Emergency Department Phase 1-3 Hours

Plan of Care		Evaluation	Comments
Progression Outcomes	*Neurological status stable @ baseline *Oxygenation & ventilation adequate	O Met O Unmet O NA O Met O Unmet O NA	O ICH O Ischemic If ICH, discontinue pathway after the ED phase is complete
Assessment & Evaluation	Neuro Deficits Assessed q 30 minutes X 2 Vital signs WNL/parameters set by MD	O Met O Unmet O NA O Met O Unmet O NA	
Diagnostics	As Ordered:_____	O Met O Unmet O NA	
Treatments	Oxygen Continuous cardiac monitoring	O Met O Unmet O NA O Met O Unmet O NA	
Medications/ IV Fluids	IV fluids rt-PA (to be given only within 3 hours of symptom onset) Ordered ☐☐:☐☐ Administered: ☐☐:☐☐ Heparin protocol O Standard O LowDose O Not Ordered O Individual heparin dose per MD Ordered ☐☐:☐☐ Administered: ☐☐:☐☐ Antihypertensives	O Met O Unmet O NA O Met O Unmet O NA O Heparin Bolus O Met O Unmet O NA	rt-PA: Time from symptom onset to rt-PA administration ☐☐:☐☐
Diet & Nutrition	NPO	O Met O Unmet O NA	
Elimination	Bladder function evaluated	O Met O Unmet O NA	
Activity & Safety	Bedrest	O Met O Unmet O NA	
Education	Patient/Family informed of diagnosis and treatment plan Transfer to an inpatient unit explained	O Met O Unmet O NA O Met O Unmet O NA	
Consults & Referrals	Neurologist response: Arriveaw/in: O 30 min O 30m - 1hr O 1-2hrs O 2-3hrs O 3-4hrs O > 4hrs O Refers to private teaching O Refers to attending O Will see in AM On call stroke nurse arrives within 30 mins of page	O Met O Unmet O NA O Met O Unmet O NA	Neurologist arrival time: ☐☐:☐☐
Psychosocial & Discharge	Transferto: O NICU O 5 Neuro O Other_____ Time from order to admit/transfer to inpatient unit until actual transfer occurs: O <1 hr O 1-2hrs O 3-4hrs O 5-6hrs O 7-8hrs O >8		

Signatures	Nurse Signatures		Multidisciplinary Signatures
	/	07:00-15:00	/
	/	15:00-23:00	/
	/	23:00-07:00	/

12/12/01

47394

Memorial Health University Medical Center

Clinical Pathway: **CVA (Ischemic or ICH DRG 14)**

Anticipated LOS: 5.0 **Days**

Date: ☐☐ / ☐☐ / ☐☐

Patient Identification ☐☐☐☐☐☐☐☐☐☐

☐ Ischemic
☐ ICH

Room # ☐☐☐

Day 2

Plan of Care		Evaluation	Comments
Progression Outcomes	***Neurological status unchanged or improving**	O Met O Unmet O NA	
	***Oxygenation & ventilation adequate**	O Met O Unmet O NA	
	***Appropriate diet implemented**	O Met O Unmet O NA	
	***Knowledge of diagnosis and treatment plan**	O Met O Unmet O NA	
Assessment & Evaluation	***Vital signs WNL/parameters set by MD**	O Met O Unmet O NA	
	***Skin intact**	O Met O Unmet O NA	
	Communication methods in place	O Met O Unmet O NA	
	Ischemic Diagnosis Confirmed: ☐ L Hemisphere ☐ Embolic ☐ R Hemisphere ☐ Lucunar		
Diagnostics	Carotid Ultrasound	O Met O Unmet O NA	
	Cardiac Echo	O Met O Unmet O NA	
	PT/INR if on coumadin (per MD order)	O Met O Unmet O NA	
	PTT (per Heparin protocol)	O Met O Unmet O NA	
	Swallowing evaluation if indicated	O Met O Unmet O NA	
Treatments	Oxygen	O Met O Unmet O NA	
	Cardiac Monitor	O Met O Unmet O NA	
	Correct positioning of flacid extremity	O Met O Unmet O NA	
Medications/ IV Fluids	Continuous IV / Consider D/C if appropriate	O Met O Unmet O NA	
	Antihypertensives PRN	O Met O Unmet O NA	
	O Plavix O Ticlid O Aggrenox O Other O Coumadin O Persantine O ASA	O Met O Unmet O NA	
Diet & Nutrition	Aspiration Precautions	O Met O Unmet O NA	
	***Diet as indicated (HOB up 90 degrees while eating)**	O Met O Unmet O NA	
	O 100% O 75% O 50% O 25% O 0%	☐ Liquid ☐ Soft ☐ NPO	
Elimination	Foley catheter	O Met O Unmet O NA	
	Voiding without incontinance	O Met O Unmet O NA	
	Bowel Movement	O Met O Unmet O NA	
Activity & Safety	***Out of bed BID total of 2 hrs (Nursing +Therapy)**	O Met O Unmet O NA	
	HOB up 30 degrees	O Met O Unmet O NA	
	Falls protocol ongoing	O Met O Unmet O NA	
	Assistive devises/orthoses	O Met O Unmet O NA	
Consults & Referrals	***Document appropriateness of Rehab referral**	O Met O Unmet O NA	
	O PT O OT O ST O Dietician O RN Case Manager O SW Case Manager O Pharmacist O Diebetic ducator O MD_____		
	Recommendations for further therapy: O Inpatient O Home & OP Therapy O NH O Home with Day Rehab O Subacute O Home with Home Health		
Psychosocial & Discharge	***Discharge options reviewed with patient/family**	O Met O Unmet O NA	
	Psychosocial information reviewed	O Met O Unmet O NA	

Signatures

Nurse Signatures

Multidisciplinary Signatures

/ 07:00-15:00 /

/ 15:00-23:00 /

/ 23:00-07:00 /

49005

NEWS BRIEF

On-line health information aids with decisions

Recent studies indicate that the number of people in the United States who seek health care information on-line has doubled since 1998, and that those who search the web for such material say it has an impact on their decisions.

The number of people who go on-line for information about health topics has grown from 54 million in 1998 to 110 million this year, according to a survey by Rochester, NY-based Harris Interactive, a worldwide market research and consulting firm.

Sixty-eight percent of Americans searching the web for health care information say the information they found on-line had some impact on their decisions, according to a study by the Pew Internet & American Life Project in Washington, DC.

That would appear to be good news for hospitals and health systems hoping to increase their visibility and accessibility through use of the Internet. The Pew study found that the typical "health seeker" accesses two to five health sites found through a search engine and spends at least 30 minutes on the search. One-third of the health seekers brings relevant information to their physician.

However, the study found that 73% of health seekers rejected information found on-line for various reasons, including that information appeared too commercial or because they couldn't determine the source of the information. The report, *Vital Decisions: How Internet Users Decide What Information To Trust When Their Loved Ones Are Sick*, can be found at www.pewtrusts.com.

The Harris Interactive survey found that the most visited health sites in the United States are for medical journals, commercial health pages, and academic or research institutions.

Some respondents said they look for information only if their physician tells them to do so, but others say they judge the information on their own without consulting their physician.

For more information, go to the Harris Interactive web site: www.harrisinteractive.com. ■

Don't miss an opportunity with conference replays

American Health Consultants is offering a replay of two of its most popular audio conferences — **Avoiding Medication Errors: Saving Lives, Time, and Dollars**; and **Put It in Writing: Keys to Effective Documentation** — at the subscriber-only rate of $149 each. Don't miss out on this special opportunity to educate your entire staff at your convenience for one low facility fee. Each hour-long replay includes handouts, additional resource materials, and free CE and CME for your entire staff.

The first replay, **Avoiding Medication Errors: Saving Lives, Time, and Dollars**, will run from 8:30 a.m. Aug. 13 to 5:30 p.m. Aug. 14. This essential audio conference provides practical strategies and advice on how you and your facility can avoid costly medication errors, which can result in the deaths of more than 7,000 patients annually. Learn how you can prevent these deadly errors and the devastating effect they can have on your facility. Leilani Kicklighter, RN, ARM, BS, MBA, DFASHRM, CPRHRM, a risk management specialist, and Stephen Trosty, JD, MHA, HRM, director of risk management for the Mutual Insurance Corp. of America, will present the conference. These two highly experienced risk managers give you valuable tips on how you can avoid the damage medication errors can cause to your patients and to your institution, as well as guide you through the controversial concept of self-reporting errors.

Put It in Writing: Keys to Effective Documentation, will be replayed from Aug. 20-21 starting at 8:30 a.m. and concluding at 5:30 p.m. Aug. 21. The need for thorough and accurate documentation is crucial in health care. Inadequate documentation can result in claims denials, lawsuits, and even criminal investigations. Learn the keys to effective documentation and how it can benefit your facility. The conference is presented by Deborah Hale, CCS, president of Administrative Consulting Services, and Beverly Cunningham, RN, MS, director of case management at Medical City in Dallas.

To sign up for either replay, or for information on upcoming live audio conferences, call customer service at (800) 688-2421. You will be given a dial-in number and conference call access code. Conference material will be available on-line once you register.

When ordering, please refer to the following effort codes for each conference: Medication errors, 61991; Documentation, 62001. ■