AMERICAN HEALTH CONSULTANTS

# HOSPITAL CASE MANAGEMENT™

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

## IN THIS ISSUE



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# Flowcharts help medical center boost pneumonia outcomes

*Guidelines reduced variation*

Last year, Advocate Christ Medical Center at Hope Children's Hospital in Chicago decided to take a snapshot of how it was treating pneumonia patients. What it discovered, reports **Sharon Otten**, a care management utilization review specialist, is that 87% of the patients diagnosed with pneumonia were entering the system through its emergency rooms. However, there was very wide variation in the cost per case and in the use of antibiotics.

Physicians each had their own "boutique package," which they felt was the best way to treat patients, says **Letisha Losurdo**, manager of performance improvement at Advocate. "We didn't have a goal out there for people to really work toward and achieve."

## Audio conferences tackle critical compliance issues

*Don't run the risk of fees or losing your accreditation*

Health care organizations today are challenged by more than just providing quality patient care. Compliance issues can create headaches for facilities that aren't prepared. How well does your facility meet certain regulations? Is your staff properly armed with the most up-to-date information? To help you prepare, American Health Consultants offers two upcoming audio conferences dealing with current, hot-topic compliance issues: pain management and needle safety.

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According to Otten, the key indicators were not length of stay or cost per case, however. "Our focus was really on improving the clinical care for the patient," she says.

Because of the variances identified, the hospital decided to look more closely at treatment at the site level. Advocate consists of eight hospitals, a home care agency, and several clinics. Christ Hospital, which is part of that system, has 662 licensed beds. It is a Level I trauma center, a Level III perinatal center, and a not-for-profit teaching facility.

Otten says the hospital's case management model has two primary focuses — care coordination and social services. Twenty-seven full-time nurses are devoted to care coordination and utilization review, while 16 social workers perform counseling and discharge planning. The caseload for the care coordinators is about 22 to 29 cases, while the caseload for social workers is between 30 and 50. For the most part, they are unit-based, Otten says.

The average cost per case for pneumonia was roughly $5,500 in 1998 but rose steadily to almost $6,400 per case by 2001. Meanwhile, pneumonia length of stay gradually declined from six days in 1998 to five days by 2001. That led Advocate to question if there was an opportunity for improvement. "Our cost per case was rising despite the decrease in the length of stay," Otten says. "We really felt that we needed to drill down to the case level to see what was going on."

According to Losurdo, the hospital discovered it was doing a good job of processing patients through the system but that the process was cluttered by steps that could be eliminated to make care more efficient. "We also found that some of our patients could benefit from screening," says Losurdo. She says the hospital discovered that not all cases required aggressive antibiotic therapy and that some patients could benefit from an outpatient regimen.

In short, it became apparent that while the hospital was doing a good job of treating pneumonia, it was not working efficiently as a team in treating those patients, Losurdo says. "We weren't connecting the care, monitoring the care, and really collaborating through the continuum," she says.

According to Losurdo, the majority of patients — between 85% and 95% — entered the system through the emergency room, where they were evaluated and diagnosed with pneumonia. Advocate decided to focus its attention on appropriate selection and timing of antibiotics and the switch from intravenous therapy antibiotics to oral antibiotics.

### *Reducing variation*

Losurdo says the best way to eliminate variation is to implement standards or guidelines for people to follow. Advocate researched the literature to examine those guidelines and sought out local physician experts to improve patient outcomes while reducing the length of stay and cost per case.

The hospital also initiated performance improvement using a flowchart, which Losurdo says is the ideal tool for this process because it helps illustrate the components of care. "It helped us to see where we had delays in our process and where we have redundant steps, and capitalize on opportunities for improvement," she explains.

If the antibiotics were administered in the emergency department, that process was expedited. Patients were assigned to the medical unit, where nurses again assessed the patient. "We looked at the assessment of the patient, determined if the patient was on the appropriate antibiotics, and observed the response to treatment," she says.

During that process, the team looked at the possibility of switching from intravenous therapy antibiotics to oral antibiotics. The team also examined variations in practice among physicians and found that it was not taking full advantage of guidelines and recommendations for the treatment of pneumonia.

Losurdo says the hospital used the flowchart to gauge treatment and examine how the team functioned. While the right resources typically were involved, she says there was limited collaboration among the various disciplines. "Everybody was on their own mission out to accomplish their component of care," she says. "We were handing off treatment to each other and not collaborating over that treatment."

According to Losurdo, the assessment of the flowchart revealed opportunities for improvement along with specific actions. For example, the hospital added the use of admissions screening and risk stratification criteria to make sure it was identifying patients who required aggressive antibiotic therapy as well as those who could be treated at the outpatient level.

Losurdo says one critical area that was examined was the recommended drug of choice. "We published antibiotic guidelines for use and recommendations for IV-to-oral switch times," she reports. "We looked at the data and wanted to capitalize on the information that we had."

Because the vast majority of patients entered the system through the emergency department, a goal was established to administer the first dose of antibiotic within the first four hours of care.

## *Team thinks outside the box*

In looking at the long-term goals for pneumonia, Losurdo says Advocate wanted to incorporate some "out-of-the-box" thinking. "We looked at what it would do to our larger picture and how it would really help us to decrease mortality and morbidity rates and what we could do to optimize our ability to manage our own beds," she says.

In addition to developing guidelines to standardize treatment, the hospital turned to professionals in its health information management department to help enhance and improve documentation and coding for pneumonia patients. "This had an impact on our ability to track and monitor the patients over time," says Losurdo.

Advocate uses a proprietary system for its physicians called Care Net. Some of the tools for the pneumonia initiatives then were linked to that system to enable physicians to access resources.

The data package included baseline data, which were used to plot progress on a monthly basis. "A consulting group was used to help collect the baseline data," she adds. "They helped us to develop the data collection tool that would be used by all of the Advocate sites so that we would be able to compare data and initiatives and progress over time," she explains.

The hospital reviewed benchmark opportunities and made a plan to share data and share success stories. "What other sites had found to be successful hits in their projects, we shared and implemented within our own sites as well," she says.

While the site initiatives for the system were being established, a number of questions were considered: How are patients identified and diagnosed? What practices should be targeted related to pneumonia? What antibiotics would be selected as the antibiotics of choice? How could the first dose be administered within that four-hour window of care?

The systemwide initiative established the framework for the site objectives, Losurdo says. "To accomplish these site objectives, we needed to make sure that we had the right team players," she says. "We had the right representation, but we needed to refresh our team to really drive actions forward."

The site teams and the system team both were led by physicians, and the physician who led the system initiative was the "site champion," she says. "We had the best of the best."

The team comprised physician representation from internal medicine, family practice, pulmonary medicine, and the emergency department. Also included were representatives from the resident health staff, nursing, epidemiology, and care management. Ancillary resources, such as labs, health information management professionals, social services, and pharmacists also were included.

Losurdo says performance improvement assisted the team by bringing structure to the process and by being able to analyze the data.

Once the objectives were established, the hospital was able to implement specific actions to drive the initiative forward in the most aggressive fashion possible, according to Losurdo. To accomplish that, it used an action plan to identify specific goals, determine who was accountable for those goals, and establish target dates.

"The beauty of it is that our physician leader actually used the action plan," Losurdo says. "This is music to a performance improvement person's heart, because these are tools that really help us and charge us in the mode of accountability."

## *Educating physicians and staff*

According to Losurdo, the first key component was education, which raised the level of awareness and knowledge related to the pneumonia initiative.

"Our tools guided our approach to care and helped to raise the levels of awareness of our pneumonia project," she says. "The more awareness you have, the more likely you are to have people to continue to buy in and to keep your initiative charged."

According to Losurdo, the team used a variety of tools to help get the information in front

of people, including posters in patient units, physician lounges, resident lounges, and even bathrooms. The team used resources from the Illinois Foundation for Quality Healthcare, the local quality improvement organization.

Another tool used was a white card that clipped to a name badge that served as a reminder of the three key initiatives: the selection of antibiotics, the timing, and the switch timing.

In addition, the team used a trifold that easily fit in a pocket. "We furnished these to our physicians, our house staff, and to our care managers so that they could be pulled out and referenced, so that we were constantly reinforcing the use of screening criteria and risk stratification," she explains.

Two additional tools also were very important, says Losurdo: guidelines for the use of antibiotics, and a surveillance tool. The guidelines were put on the front of the patient chart and used as a reminder for physicians to help reinforce the use of selected antibiotics, the timing of the antibiotics, and the IV-to-oral switch time.

The surveillance tool was used primarily by care managers and epidemiology team members to conduct concurrent case monitoring of pneumonia patients. "We considered this to be a living, breathing, working document," she says. "Most importantly, what this tool did for us was to prompt an immediate interaction and intervention with the attending physicians."

Losurdo says this process helped pull in all of the key pieces involved in pneumonia care to provide a visual picture of that care. She says that visual picture was used to drive the ongoing assessment of patients and move them toward the switch time.

"We tried care paths in the past and, to be honest, they didn't work," Otten says. "Physicians viewed it as a nursing document; nurses were all too busy to use it; and it really wasn't an active piece of information for anybody."

Advocate did not attempt to reinvent the wheel, says Otten. "What we did was to spin it a little differently, beginning with the point of entry." She says that included criteria for admission and risk stratification in addition to developing a treatment plan that included the timing and selection of the appropriate antibiotics.

According to Losurdo, the flowchart is central to the process. The clinical evaluation and screening and the risk stratification is the first decision point. If a patient falls into risk class one or two, the hospital considers initiating an oral antibiotic and discharging the patient.

If the patient falls into risk classification three, four, or five, the hospital considers an inpatient approach with an antibiotic ordered in the emergency department based upon its published selection of antibiotics. "We look at the first dose to be given while the patient was in the emergency department and then the transferring of care of the patient to the inpatient unit," says Losurdo.

Losurdo says this is where the interdisciplinary team came into play and changed the approach to patient care through collaboration among epidemiology, care management, the attending physicians, social workers, and pharmacists.

According to Losurdo, there was a bonus to the initiative. "Not only did we accomplish our main goals, but we also looked at the impact that it would have on our ability to better recognize our opportunities for lengths of stay and cost reduction," she says. The team recognized there might still be "an antibiotic loop" in the flowchart, but when that occurs now, it is due to a culture-resistant organism.

Losurdo emphasizes that the composition of the team did not change between 2001 and 2002. "What changed was our team dynamics and how we used the people that comprised the team," she explains. "The team achieved success through ongoing communication and collaboration."

### *Collaboration included epidemiology*

Also key to the process were the resources of the epidemiology nursing team, which collaborated with the clinical bed management team. Losurdo says epidemiology began sitting in on bed management meetings in the mornings so that they could identify the patients who were admitted through the emergency department and follow them at the unit level. This had a major effect, she says.

Epidemiology also collaborated with care management and the attending physicians. "Care management worked closely with our physicians, with epidemiology, and with our pharmacy resources to assess care and look for the opportunity to target that IV-to-oral switch time," adds Losurdo.

In addition, social services now is in a more optimal position to plan for the patient's discharge and any needs that patients or their families might have, says Losurdo. "This had a huge impact on our ability to be efficient," she says. Pharmacy worked not only to guide the switch time, but also was central to ensuring the most appropriate oral antibiotic for the patient, she adds. ■

# Severity measure helps ensure timely discharge

*Judging when to discharge pneumonia patients*

Hospitalized pneumonia patients who have abnormal vital signs, mental confusion, or problems with eating or drinking in the 24 hours prior to discharge face a greater chance of hospital readmission or death than do other pneumonia patients. These are the findings of a recent study funded by the Agency for Healthcare Research and Quality and conducted by a team of researchers led by **Ethan Halm**, MD, MPH, of the Mount Sinai School of Medicine in New York City[1].

Halm and his colleagues focused on the potential danger of releasing pneumonia patients from the hospital "quicker and sicker." They developed a simple severity-of-illness measure for patients with pneumonia that clinicians can use to judge whether it is safe for the patients to be discharged from the hospital.

The measure uses information from the five basic vital signs (temperature, heart rate, blood pressure, respiratory rate, and oxygen levels in the blood) that are checked several times a day in hospitalized patients, as well as an assessment of the patient's mental status and ability to eat and drink.

Halm and his colleagues found that patients who were discharged "medically unstable" — defined as having problems with at least one of the seven factors in the measure — had a 30% higher chance of readmission or death and a 50% higher chance of not returning to their usual activities within 30 days. Medically unstable patients constituted 20% of pneumonia discharges in the study. In addition, the researchers found that the small proportion of patients who were discharged with two or more unstable factors had a fivefold greater risk of readmission or death.

The researchers contend that hospital and insurance plan guidelines that shorten the length of hospital stays should build in a safety check to measure clinical stability prior to discharge to make sure that patients are not sent home too soon. Halm also suggests that measuring stability before discharge can be used as an indicator of quality of care.

## Reference

1. Halm E, Fine M, Kapoor W, et al. Instability on hospital discharge and the risk of adverse outcomes in patients with pneumonia. *Arch Intern Med* 2002; 162:1278-1284. ■

# Knowledge of competencies key to successful CM

*Competence isn't the same as performance*

For many case management departments, simply coming up with a workable job description for case managers presents such a challenge that measuring competency often is hardly considered at all. "People have a hard enough time trying to figure out what a case manager is supposed to do," says **Tahan Hussein**, MS, DNSC(c), RN, CNA, director of cardiovascular nursing, Nursing Administration, at Columbia Presbyterian Medical Center in New York City.

Hussein says the existing body of knowledge and literature does not offer any consistency or standardization in terms of case management practice and case managers' functions. "That makes it difficult to measure competencies or performance," he notes.

Hussein says there often is confusion about what competence and performance mean. "People sometimes use the two terms interchangeably when they are not," he says.

Hussein emphasizes that competence and performance must be differentiated before measuring competence can even be considered. "Performance is basically associated with task completion and not necessarily the rationale behind the task, or how well the task was completed and what its outcomes were like," he explains.

For example, a case manager may assess a patient and complete that assessment. "That does not mean the case manager was competent in finishing that task effectively, efficiently, appropriately, or thoroughly," he says. It also does not mean that the desired outcomes were achieved. "Performance is basically the act of completing something — an activity," Hussein explains. "There is no judgment on or evaluation of the outcome of that task."

By contrast, competence points to a case manager's ability to complete a task through a process that integrates knowledge, skills, behaviors, and attitudes, Hussein says. In addition to simply completing the task, he says, it also means:

- identifying the knowledge areas that must be applied for effective completion of that task;
- determining the kinds of skills that are required for successful completion of that task;
- selecting the specific performance behaviors that must be applied to ensure meeting the

expected outcomes.

Only then can a case manager say he or she has finished that task effectively, successfully, and competently, Hussein says.

"Competence is the ability to tie all those different areas together as you are involved in a situation, event, function, role, or task," he says. It also means making sure the outcome of completing a task is the desired outcome for the organization, the patient, the provider, and the insurer/payer.

When it comes to applying this framework to case management, the place to start is the focus and goals of the case management program, Hussein says. Hospital leaders should begin this process by reviewing the goals and objectives of their case management program. Based on that assessment, they should then identify core measures they can use to evaluate the competencies and performance for case managers.

For example, if the primary focus of the case management program is utilization review and management, "it will be necessary, for example, that you measure the case manager's competence in areas of certification/authorization of services, reversing denials, writing appeal letters, and enhancing reimbursement," he says. In other words, there is no point in measuring the clinical dimension of the case manager's role if your goal is basically utilization management and resource management, he says.

In this case, Hussein says the hospital should measure competence in terms of the case manager's ability to conduct appropriate managed care reviews and negotiate lengths of stay and transitional plans. "The case manager must be able to negotiate the plan of care that will meet the resource or utilization management guidelines with the health care team," he says. Most of these aspects of the role are cost-based or utilization and resource management-based but aren't necessarily concerned with actual direct care provision or clinical care at the bedside, he points out.

According to Hussein, this is where many people become confused. They design their case manager job description and determine how they are going to measure the performance or competence of the case manager as if they were two separate and independent entities, he says. They also lose sight of the goal of their case management program, he argues.

Hussein says this approach results in a disconnection between the goals of the case management program, the case manager's job description, and the case manager's competency measures. Such fragmented planning makes the process of measuring competencies more challenging and less fruitful. "In designing a competence-based performance evaluation of the case managers, you have to integrate the three components together — program goals, job description, and competency measures — rather than separate them," he says. "One is going to lead into the other." ■

# Malpractice issues likely to plague CMs in future

*Follow job descriptions, rules to avoid liability*

Case managers are being identified as defendants in medical malpractice and negligence lawsuits, and their liability exposure is likely to increase in the future, says health care consultant **Cathy Nearhoof**, RN, BSN, CCM, NMCC, CLNC.

Nearhoof, owner of Pittsburgh-based Integrist Healthcare Consulting, works with both plaintiff and defense attorneys and insurance companies by assessing, researching, and preparing medical malpractice, personal injury, workers' compensation, and criminal cases for litigation.

It takes so long for legal issues to work their way through the system that lawyers currently are dealing with issues that arose in the mid- to late 1990s, Nearhoof says.

"Prior to then, there was little documentation in the medical records with case managers. Now, there is an increased inclusion of case managers within the health care system, and attorneys are not always knowledgeable about the role of a case manager. Needless to say, plaintiff attorneys are delighted to identify an additional defendant or someone who can be deposed and/or potentially increase the strength of their case," she adds.

A case manager's inclusion in a malpractice case is based on a review of the medical records, an assessment of the case manager's expected role, and a determination of whether the case manager might have breached his or her duty based on established case management standards of care.

"The answer to the possibility of a breach of duty is found in the job and program description." Nearhoof says. "The question becomes: Did that case manager do what the hospital or the employer said they would do?"

*(Continued on page 143)*

# Is your ED ready for HIPAA? How to protect privacy

*You'll need strategies to avoid being noncompliant*

Patient records left on a desk in full view. Interviewing a sexual assault patient in easy earshot of others. Answering a caller's question about whether a certain person is being treated in your emergency department (ED).

These may be common occurrences in your ED, but as of April 2003, they also may be violations of the Health Insurance Portability and Accountability Act (HIPAA).

"It's this year's Y2K," says **Jeanne McGrayne**, director of emergency department strategies for VHA Consulting Services, a nationwide network of community-owned health care systems, based in Charlotte, NC.

"Ultimately, we're all going to have to comply, just like with the Joint Commission [on Accreditation of Healthcare Organizations]," she says. "And the bottom line is: It's the right thing to do."

Violations of HIPAA are a major concern, especially since the criminal penalty for disclosing patient information without malicious intent is up to $50,000, plus one year in prison.

The biggest challenge for ED case managers, says **Jonathan Kent**, RN, CEN, assistant director of the emergency center at Medical Center of Central Georgia in Macon, is protecting privacy in a crowded, noisy ED.

"Patients have as much desire for the world to know their medical complaints as they have to show them the color of their underclothes, but we are still not perfect at protecting the privacy of our patients," he says.

Here are effective ways to comply with HIPAA requirements for patient privacy:

• **Protect patient records from view.**

You will need to have a secure place for all patient records, McGrayne says. She gives the example of digital X-ray systems that list patient names at the bottom and may be viewed at various workstations. "You need to consider where you put those screens and ensure that the patient's name is not visible," she says.

She notes that one hospital has a practice of delivering medical records to the ED for all patients being treated. "This is a best practice because it's better for the patients if their clinical history is available to providers."

However, HIPAA will require records to be secured, she says. "Right now, they are laying all over the place," she says. "Anyone could walk through the ED, pick up one of the records, and walk away with it. It can be very serious."

The front page of a patient's chart may be visible, since many EDs keep charts at the bedside or the front desk, McGrayne says.

She offers the following solutions:

— scanning and automating access to old records;

— centralizing records;

— putting a cover page over demographic information;

— using binders that protect patient information.

• **Use a sign-in sheet that conceals patients' names.**

Medical Center of Central Georgia's ED uses a triage sign-in sheet consisting of a multipart form with individual tear-off tickets. As each patient signs in, a list that is concealed behind a cover sheet is generated with the name, time, and chief complaint.

The form includes a place to write a telephone contact number, should the patient decide to leave prior to being seen by the triage nurse, Kent adds.

# Clinical trials harmed by lack of informed consent

*Patients need answers to tough questions*

The mention of clinical trials often triggers a silence between physician and patient, usually because neither one knows much about the subject. Nearly 80% of physicians admit they would like to know more about clinical trials so they can help their patients make an informed decision before volunteering to participate.

"Most subjects enrolled in clinical studies have a meager understanding of what they have gotten into," says **Alan Sugar**, MD, chairman, New England Institutional Review Board, Professor of Medicine, Boston University School of Medicine, Boston. "Informed consent has largely focused around the signed form and has not practically become the continuous process that it needs to be. As a result, a subject's misunderstandings largely go unchallenged."

Properly informing patients is not only ethically necessary, say clinical trials experts, but it also ensures better trials and data. Last year, more than 17 million people thought seriously about participating, but only a few million actually completed their trials. And even among them, many gave their consent without a thorough knowledge of the facts.

"There's a simple ethical mandate that you don't ordinarily do dangerous things to people without their knowledge and consent," says **Dale E. Hammerschmidt**, MD, FACP, associate professor of medicine and director of Education in Human Subjects' Protection for the University of Minnesota Medical School in Minneapolis. "From a more pragmatic perspective, a well-informed subject is likely to cooperate better with the trial and is more likely to report potential problems. The quality of the data and the safety of the trial are both enhanced when the subjects really know what's going on."

Indeed, patients can be so daunted by questions and lack of information that they simply decide not to volunteer.

A new resource, written for doctors and clinical trial participants, can help answer some of these tough questions. CenterWatch in Boston, the leading publisher of clinical trial news and information, now offers "Informed Consent," a consumer's guide to the risks and benefits of volunteering for clinical trials. The book is a practical guide through the confusing world that patients perceive clinical trials to be.

"Informed Consent" is a step-by-step guide that begins with a history of the clinical trials industry and explores the drug development process and how a new drug makes its way to the marketplace. The book goes into detail about why people decide to participate, how to find clinical trials, how to research clinical trials and evaluate their risks, how to ensure proper informed consent, who the vulnerable populations are, and what to do when things go wrong.

The cost of "Informed Consent" is $16.95. It can be ordered from CenterWatch at (800) 765-9647, or by faxing your request to (617) 856-5901. It can also be ordered through centerwatch. com, Amazon.com, and barnesandnoble.com. ■

• **Limit what other patients can hear.**

McGrayne warns of the common practice of ED physicians dictating patient outcomes in open workstations, which discloses sensitive information to those standing around the desk. "If planning for a new facility, ensure there is adequate space for dictation or telephone discussions, to allow for privacy," she says.

Another solution McGrayne offers is investing in automated documentation features that eliminate verbal dictation altogether. She suggests using the HIPAA requirements as leverage to obtain this resource from administrators.

Calling out names of patients waiting to be seen is another potential problem, McGrayne says. She refers to her own consulting experiences, when asked to pose as a patient to evaluate ED processes first-hand.

"When I have done mystery patient visits and someone yells out my name while I'm sitting in a crowded waiting room, I cringe," she says. "Regardless of HIPAA requirements, I feel it's very inappropriate."

To address this concern, ED patients at Gunderson Lutheran Medical Center in La Crosse, WI, are given pagers by the triage nurse so they can be contacted confidentially, says **Stephanie Swartz**, RN, administrative director of emergency medical services.

There also is an added benefit because patients

can leave the ED waiting room area and wait in the lobby, cafeteria, or outside, Swartz says.

She notes that the cost for a pager is $140 including the charger units and transmitters, and she says the ED has not had much of a problem with the loss of pagers.

"Our customer feedback shows that patients like the privacy and the increased mobility," Swartz says.

• **Give staff inservices specifically about privacy.**

The way you educate staff about privacy requirements will be the biggest factor in determining whether you are HIPAA-compliant, according to Kent. "They are the ones who control information at the outset," he emphasizes. **(See checklist of privacy practices ED staff are instructed to use, below right.)**

All ED staff are required to complete an annual competency assessment on privacy issues and receive regular inservices on this topic, he says.

• **Dispose of health information properly.**

Kent recommends placing receptacles wherever a document with the patient's name or other identifying information is produced. He suggests using a document destruction company to empty them.

Staff are instructed to dispose of all protected health information, including embossers, plastic identification cards, floppy disks, CD-ROMs, and name bands, in one of the 10 locked receptacles located throughout the facility.

Kent notes that it's very important to place a receptacle at the automated medication dispenser. "If a receipt is generated and not used for documentation, it must be destroyed, as it has the patient's name and drug listed on it," he says.

• **Use a special code for increased privacy.**

Kent says that ED patients at his facility are offered a No Press, No Info (NPNI) special code. "Patients under this designation will have their presence in our facility neither confirmed or denied by phone or in personal contact with visitors," he says.

He explains that if any ED staff member feels a patient may desire increased privacy, such as a community VIP or a victim of violence, the NPNI designation is offered.

• **Make every attempt to increase privacy by shifting the location of patients.**

Kent says his ED staff make every possible effort to ensure audio and visual privacy for all patients, including shuffling placement in rooms and holding at least one room open for private interviews and exams.

He notes that staff may be used to needing a private space for physical examinations to protect a patient from being exposed to onlookers, but it's important they understand that interviews also may require the same level of privacy.

"It is difficult at times to make these arrangements, but we do it to the absolute limit of our capability," he says.

*[Editor's note: Proposed changes to the "Standards for Privacy of Individually Identifiable Health Information," part of HIPAA, were published in the March 27, 2002,* Federal Register. *To view the proposed rules and a side-by-side comparison of this new proposal, go to: www.aishealth.com/Compliance/HIPAARegs032202.html. To order a copy of the* Federal Register *with the proposed rule, contact New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954. Specify the date requested. Credit card orders also can be placed by calling the order desk at (202) 512-1800 or by faxing to (202) 512-2250. The cost for each copy is $10. The* Federal Register *is available at many libraries and on the web: www. access.gpo.gov/nara/index.html.]* ■

## Privacy Checklist

The emergency department staff at Medical Center of Central Georgia in Macon are regularly inserviced on the following instructions to ensure patient privacy:

- Do not share any information with friends or family members of the patient or other employees that do not have a need-to-know to adequately perform their job.
- Do not attempt to access any information on a patient that *you* do not have a need-to-know for your job.
- Do not have discussions about patients in hallways, elevators, the cafeteria, or outside the organization while off-duty.
- Do not use your code to look up information for anyone else. They should have their own code that allows them access they need.
- Always log off before leaving a workstation unattended.
- Never share your password with others or allow them to use a workstation logged on with your password.
- Never take any information outside the organization, including photocopies, printed pages, or faxed pages.
- Use cover sheets on all charts and clipboards. ■

(Continued from page 129)

The first hurdle to overcome in developing a pain management strategy is the misconception that effective pain management is not a problem within your facility or does not need to be a high priority. The audio conference **Complying with JCAHO Pain Management Standards: Is Your Facility at Risk?** is scheduled for Oct. 8, from 2:30-3:30 p.m., Eastern time. Conference speakers **Patrice L. Spath**, BA, RHIT, and **Michelle H. Pelling**, MBA, RN, will teach participants how to:

- Comply with the new Joint Commission standards relating to pain medication range orders and titration
- Integrate the Joint Commission's "Speak Up" campaign into your patient education initiatives. The groundbreaking program encourages patients to become active, involved and informed participants on the health care team
- Develop a performance measurement system to evaluate the effectiveness of pain management and continually monitor and improve outcomes
- Avoid documentation deficiencies and staff complacency that can derail your pain management program

This audio conference is a must for hospital nursing directors and staff nurses, pharmacists, pain management team members, quality directors, risk mangers, accreditation/compliance directors, patient educators, case managers, ED managers/nurses, same-day surgery managers, and home health managers.

### *Prevent fines and needlesticks*

Emboldened by new federal laws, the Occupational Safety and Health Administration (OSHA) dramatically has stepped up enforcement of needle safety provisions. In a flurry of activity between July 2001 and May 2002, OSHA issued a staggering 1,876 citations for those who still haven't gotten the message that needle safety is now the law of the land. These unfortunate facilities were slapped with $1.3 million in fines, and contrary to popular belief, only about 20% of the expensive inspections were prompted by an employee complaint.

With random visits a possibility, you need to know the latest regulatory information to ensure you can pass muster with OSHA while protecting your employees and patients. **Sharps Safety Compliance: How to Avoid OSHA Citations and Costly Fines** is slated for Wednesday, Oct. 23, 2002, from 2:30-3:30 p.m., Eastern time. Our program will feature practical handouts and guidance along with the answers to some of your most pressing questions.

OSHA expert **Katherine West**, BSN, MSEd, CIC, veteran infection control consultant at Infection Control/Emerging Concepts in Manassas, VA, will review the latest OSHA requirements and give you the inside tips necessary to pass any future inspection with flying colors. **Bruce E. Cunha**, RN, MS, COHN, manager of health and safety at Marshfield (WI) Clinic, has 24 years working experience on the frontlines of occupational health and safety. He will provide vital insight on what practitioners can do to ensure safety for clinical procedures for which there are currently no safety needles available. This conference is critical information for infection control professionals, employee health professionals, ED managers, physicians, nurses, risk managers, compliance directors, case managers, home health professionals, and same-day surgery managers.

Educational programs for hospital staff at all levels can ensure that sound pain management and sharps safety standards are understood and put into practice throughout your facility. To sign up for either conference, call American Health Consultants at (800) 688-2421 and mention effort code 62751 for pain management and 62761 for sharps safety. The facility fee for each program is $299, which includes free CE for pain management and free CE or CME for sharps safety. Also included with each conference package are program handouts and additional reading, a convenient 48-hour replay, and a conference CD. If you sign up for both audio conferences, your cost is only $500. That's a $100 discount. Don't miss out. Educate your entire facility for one low fee. ■

## 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 1200 words long.

Send your article submissions to:

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

AMBULATORY CARE
QUARTERLY

# Cut medication errors in half with ED pharmacist

*$61,000 saved in one month*

By the time emergency medical services arrived at University of Texas Southwestern Medical Center in Dallas with a 2-year-old boy who had ingested his mother's ramipril and labetalol, the ED's pharmacist already had prepared detailed information sheets for the nurse and physician. Those sheets listed the care pathway for each agent involved, appropriate evidence-based management, potential side effects, necessary lab tests, and complications that might occur. This type of scenario now occurs in the ED on a daily basis, due to the use of a dedicated on-site pharmacist in the ED, says **Paula J. Mialon**, PharmD, the facility's clinical pharmacist for emergency medicine.

This individual responds to codes, reviews medications before administration, and educates staff on important issues related to risks and alternatives, says **Robert A. Wiebe**, MD, FAAP, FACEP, professor and director of the division of emergency medicine and department of pediatrics at the facility. Although the program started only a year ago, there have been dramatic results, Wiebe says. "This program is still maturing, but we have some preliminary data that show a 50% reduction in medication errors since the pharmacist has been on site," he reports. This alone has been enough justification for hospital administrators to allocate this resource for the ED with 24-hour coverage, he says. He reports that four clinical staff pharmacists soon will be providing coverage for more than 95% of the patients seen through the ED.

Here are some benefits of having a dedicated pharmacist in the ED:

• **Staff are assisted with complex medication issues.** Mialon serves as the link between the central pharmacy and the ED for drug delivery and administration and acts as a resource for the medical and nursing staff. She gives inservices on drug calculations, toxicology, and rapid sequence induction pharmacology to ED nurses. As a result, clinicians are freed from having to worry about dosages, drug interactions, complications, and routes of administration, Wiebe says. "It isn't just a convenience," he says. "This allows us the luxury of devoting our time and energy to other critical patient care issues."

Wiebe notes that new drugs are appearing daily, and each new drug has pharmacokinetic issues that create problems for the clinician. "The pharmacist is the expert in drug delivery, interactions, and complications," he says.

## *Helping nurses manage side effects*

Mialon explains that she reviews the patient's entire list of medications, including herbal products or teas, over-the-counter drugs, and vitamins. She notes that any of these may cause clinical symptoms that may imitate or mask another disease. She also points to patients on complicated drug regimens at home, such as a patient who comes to the ED with active seizures. "He takes Tegretol at home, and we run a level, and it is critically low. The next question is, how much do we give him to get him controlled again?" she asks. In this case, Mialon would calculate his pharmacokinetic parameters, make clinical recommendations based on the results, and review the patient's history to rule out potential adverse drug interactions.

Next, Mialon provides nurses with information about preparation and delivery of the medication and potential side effects. "Should a side or adverse effect occur, the pharmacist is there to help with management," she says.

• **Medical errors are reduced.** Orders are reviewed for appropriateness, dose, route, and frequency, and determining if the agent is the

*(Continued on page 141)*

# Emergency Department Pharmacist Activities

The following activities are performed by the Emergency Department Clinical Pharmacist. They are presented in order of importance, with the most important activity presented first.

- Continuously seek out interventions by making rounds in the medical, trauma, and observation units. Clinical pharmacist offers suggestions and assists in preventing medication errors from occurring.
- Suggest appropriate medication and/or dose recommendations where necessary.
- Assist in drip calculations and medication dosing and drip compatibility, particularly in code/trauma situations.
- Perform pharmacokinetic dose checks and make recommendations on dose adjustments for anti-epileptic medications, phenytoin, theophylline, digoxin, and aminoglycoside orders, and TDM of other meds as necessary.
- Serve on medical and trauma code response teams. Attend all incoming transport patients until deemed stable or transferred to another area.
- Aid in the management of the poisoning/toxicology patient, including review of toxin and its appropriate treatment. Aid with recommendation and utilization of appropriate antidotes to common poisons.
- Inform on adverse medication events/reactions, document occurrence. In conjunction with other members of the ERC team, design and implement plans for elimination or minimization of errors.
- Inform on medication side effects, interactions, and incompatibilities.
- Answer drug information questions from ERC staff and patients.
- Enter physician orders after review. Facilitate rapid turnaround time from pharmacy.
- Inform on drug-drug or drug-disease interactions.
- Fill emergency department outpatient prescriptions for difficult-to-find after-hours emergent prescriptions.
- Document clinical and cost-saving activities/interventions as well as routine provision of information.
- Educate medical staff on costs of comparable medications (e.g. outpatient formulary concerns), and assist prescribing habits (review of individual patient's insurance formulary to provide best possible discharge care). May include assistance in acquisition of medications from drug companies for indigent patients.
- Responsible for all pharmacy distribution issues in the ERC. Serve as liaison between pharmacy and ERC to improve medication delivery and turnaround time.
- Facilitate transfer of patient to floor/ICU by notifying floor/ICU pharmacist of situation and immediate medication needs after arrival.
- Recommend alternate drug entities during drug shortages as needed.
- Perform formal/informal consultations as needed to ERC staff as requested.
- Identify unknown medications (by name or medication itself).
- Provide and attend physician, nursing, and pharmacy inservices on emergency medicine-related topics.
- Recruit, maintain, and educate ERC pharmacy staff.
- Recommend alternate routes of administration when appropriate.
- Inservice physician and nursing staff as requested.

*Note:* TDM — Therapeutic drug monitoring
ERC — Emergency Referral Center
ICU — Intensive care unit

*Source:* University of Texas Southwestern Medical Center, Dallas.

best, most cost-effective, and safest agent available, Mialon says. "Common errors such as incorrect decimal points are intercepted," she adds.

Mialon says there is plenty of "curbside" education that takes place. "Any question we are asked, we find the answer for," she says. She uses other hospital pharmacists as a resource. "If a patient presents to the ED with a complex cardiac issue, I can call my cardiology pharmacist, who specializes in this area, for consultation." The other pharmacist may be familiar with a specific patient's history, Mialon adds. "She may know details such as the best vancomycin dose the patient tolerates, which saves someone else from starting over completely," she says.

### *Every drug provided by pharmacist is labeled*

She adds that the ED pharmacists attend all traumas and codes in the ED to assist with dosing and drawing up of medications, preparing drips such as epinephrine or dopamine, and assisting with administration. "This frees up the nurse to do other things, such as procedures and charting," Mialon says. She stresses that every drug provided by the pharmacist is labeled. "Not one syringe leaves the hands of the pharmacist to be given to the patient without a label and at least one second check by another member of the team," Mialon says.

• **Costs are reduced.** In a one-month pilot test with just one pharmacist on eight-hour days, $61,000 was saved in direct costs by switching to less expensive but equally effective agents and recommending "judicious use" of laboratory draws, particularly for drug levels, she reports. "And that's not including 'potential' reductions based on errors such as legal fees," Mialon adds. **(See "Emergency Department Pharmacist Activities" chart, p. 140.)**

*[For more information on the benefits of a dedicated emergency department pharmacist, contact:*

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# Learn how bioterrorism bill will affect your facility

*National surveillance network to be established*

If you're like most health care managers, you're eager to find out how the newly enacted Public Health Security and Bioterrorism Response Act will impact your facility. Most experts agree that the new law will result in better preparedness.

"Legislation that encompasses the entire health care system, with public health as the foundation, is a welcome event," says **Ann Stangby**, RN, CEM, emergency response planner for San Francisco General Hospital. Stangby adds that the resources allocated will benefit your emergency department (ED) operations in general, not just in terms of preparation for terrorism. "It looks like much of what is being recommended is going to enhance the health care system overall," she says.

Here are key components of the legislation, along with reactions from experts in ED management and disaster planning:

• **A national bioterrorism surveillance network will be established.** The newly created Emergency Public Information and Communications Advisory Committee will track outbreaks of infectious diseases. Stangby says this early warning system will benefit you not just in cases of terrorism but also during disease outbreaks, such as her ED's annual struggles to meet the demands of the flu season.

• **Training will be provided.** ED physicians and other health care providers will be trained to recognize and treat victims of biologic agents and other weapons of mass destruction. However, she says a key concern is lack of standardized training for all health care providers, including those in large and small hospitals, rural health centers, free-standing clinics, and urgent care sites. "I think there needs to be one approved curriculum for health care providers. It can be customized, but the basic content should be consistent," Stangby adds.

Standardized disaster training should be in the curriculum for students in medicine, nursing, pharmacy, and respiratory care, she says, and refresher training should be given periodically. "Providing certification is an excellent foundation, as it will help to maintain competencies," she says.

• **Funding will be allocated.** The legislation allocates $1.6 billion in grants to states for hospital

preparedness. "It's certain that this will translate into a large amount of funds for ED preparedness," predicts **Rich Klasco**, MD, chief medical officer for Micromedex in Greenwood Village, CO, and an ED physician at Swedish Medical Center in Englewood, CO. Micromedex is a provider of databases and integrated support tools covering information on drugs, diseases, patient education, toxicology, alternative medicine, and regulatory matters.

Klasco argues that you should take a proactive stance regarding funding. "Instead of just waiting to see what comes to you from the federal government, have a plan in your mind for what constitutes bioterrorism preparedness in your setting." He recommends going to hospital administrators armed with a list of needed resources. "Everyone is waiting to be handed their 'tool kit,' so to speak. We all need to make some decisions about our needs," he says.

**Betty Karas Bartolini**, RN, emergency preparedness coordinator at Waterbury (CT) Hospital, takes that philosophy a step further, recommending that you meet with local or national politicians to lobby for your ED's needs. She reports that representatives from her hospital recently met with Sen. Joseph Lieberman (D-CT) to discuss the bioterrorism law. "We expressed that we would like to see ongoing training available to staff members in the ED, and a disaster medical assistance team available to respond quickly in the event of a hazard," she says.

Klasco underscores the need to use hand-held computers to put information into the hands of first responders. "It's necessary to have the full spectrum of information technology available, because we don't know where the target is going to be in our information chain," he argues.

Bartolini says funding is needed to improve the ability of EDs to decontaminate patients. "We see many patients leaving the scene of a potential hazardous materials incident and making their way to the ED before they are decontaminated," she says.

*[For more information about the implications of the bioterrorism law, contact:*

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## CE questions

9. What is the case load for care coordinators at Advocate Christ Medical Center At Hope Children's Hospital in Chicago?
   A. about 15 to 19 cases
   B. about 22 to 29 cases
   C. about 25 to 32 cases
   D. about 30 to 50 cases

10. According to a study in the June 10, 2002 issue of *Archives of Internal Medicine*, what proportion of discharged pneumonia patients are "medically unstable"?
   A. one in three  B. one in four
   C. one in five  D. one in eight

11. According to Tahan Hussein, MS, DNSC(c), RN, CAN, director of cardiovascular nursing at Columbia Presbyterian Medical Center in New York City, competence is associated with task completion and not necessarily the rational behind the task.
   A. true  B. false

12. To help avoid a malpractice lawsuit, Cathy Nearhoof, RN, BSN, CCM, NMCC, CLNC, owner/consultant of Integrist Healthcare Consulting in Pittsburgh, suggests which of the following?
   A. Include the patient in conversations with the practitioner and family members.
   B. Document everything.
   C. Show sincere concern for your patients' well-being.
   D. All of the above

**Answers:** 9. B; 10. C; 11. B; 12. D

(Continued from page 134)

She suggests that case managers minimize their exposure to liability by adhering to case management standards of care, following the expectations outlined in their job description, and treating their patients professionally and with kindness and consideration. **(For more tips on avoiding liability, see related article, p. 144.)**

When a case is being considered for a lawsuit, there will be an assessment of all health care professionals who provided patient care or coordination to determine if the patient was thoroughly assessed, if his or her problems were identified, and if an appropriate plan of care was implemented, Nearhoof says.

When she assesses a case, she researches the medical records to determine whether the health care professional assessed the patient thoroughly and identified the problem correctly, and whether there were appropriate interventions in accordance with established standards of care.

For instance, she looks for documentation that the case manager made sure the specialist saw the patient before the weekend and that he or she followed up on the plan of care.

"In health care today, understaffing by nurses is reaching critical proportions. It's not uncommon to see a case manager do the assessment, put something in the care plan, and not show up until discharge. But there are so many opportunities that exist for the case manager to intervene and positively impact the care," she says.

It all boils down to duty, and no matter what your health care role is, whether you're a nurse, a social worker, or a case manager, your duty is always to the patient, Nearhoof says.

"When I see a case manager who seems to be focused only on utilization management, it sends up a red flag. Optimization of resources doesn't always coincide with what is best for the patient," she says.

Being a case manager today is often a matter of balancing what is best for the patient with what is best for the entity that pays the case manager's salary. This can be a real challenge, Nearhoof says.

"There is confusion in health care about whether a case manager is truly a case manager [or] a utilization manager with a change in title," she says.

Case managers, particularly those in workers' compensation cases, may feel conflicted about where their duty truly lies, Nearhoof notes.

For instance, if an insurance case manager handles a head injury case with a goal of returning the patient to his or her previous employment, it is important for the case manager to maintain objectivity, assessing all aspects of the injury and the potential for recovery, and establishing an appropriate plan of care with realistic return-to-work goals, she adds.

"Sometimes, insurance case managers feel that they must get the patient back to work no matter what. Getting a patient back to work is part of the

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## Editorial Questions

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

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job, but it can't be knowingly accomplished at the risk of further injury or incomplete recovery," Nearhoof says.

A case manager's duty is to assure optimal outcomes for the patient and not the insurance company, she adds.

"Sometimes it means the employer isn't going to get somebody back to work. It becomes confusing when the insurance company and/or the employer are pressuring you to inappropriately expedite the patient's recovery and return to work. It is the job of the case manager to first ensure that each patient or client receives the treatment they need," she says. ■

## To avoid lawsuits, be the best CM you can be

*Learn, and follow professional standards of care*

The best way to avoid being named in a malpractice lawsuit is "to be the most knowledgeable and professional case manager you can. Period. End of story," asserts health care consultant **Cathy Nearhoof**, RN, BSN, CCM, NMCC, CLNC.

That means familiarizing yourself with case management standards of care and following them to the letter, says Nearhoof, owner of Integrist Healthcare Consulting in Pittsburgh.

Work and study to improve yourself professionally, Nearhoof suggests. Keep up with your continuing education units, even if it means doing it on your own time and expense. Read professional journals, join professional organizations, and get certified. Certification doesn't necessarily make you a better case manager, but it does announce your commitment and dedication to the profession of case management, she adds.

Here are some of Nearhoof's other suggestions for avoiding a lawsuit:

- **Show sincere concern for your patients' well-being.**
- **Include the patient in conversations with the practitioner and family members.**
- **Don't make promises you can't keep.**
- **Document everything.**
- **Treat all patients the same — with professionalism, kindness, and sincerity — whether they are compliant or not.** "
- **Treat everybody how you want to be treated, no matter what.** ■



## 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. ■