AMERICAN HEALTH CONSULTANTS®

HOSPITAL CASE MANAGEMENT™

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

INSIDE

MARCH 1999

VOL. 7, NO. 3 (pages 41-60)

American Health Consultants® is A Medical Economics Company

Build a bigger hat rack: Case managers' duties expand to outpatient care

Increased opportunities for hospitals mean one more hat for case managers

If you've just gotten used to wearing all sorts of new hats as your clinical and financial responsibilities increase, get ready for another one: outpatient case manager.

Already, hospital-based case managers have emerged as perhaps the most important players in ensuring the success of a seamless continuum of care. While a fully integrated health care system may remain years away for many markets, some hospitals already are using case managers to extend services in the emergency department, the community, and especially to outpatient care. And, interestingly enough, smaller, rural hospitals are leading the way in many cases.

Patricia Kohler, CPHQ, CCM, RN, director of utilization management, social services, and discharge planning at Sonora (CA) Community Hospital, says expanding the duties of hospital-based case managers makes sense in terms of both cost and quality. "Case management is about coordination of care," she says. "And when you have a case manager who can bring a case together through any level of care, then you have more effective coordination and cost-effective management of the case. You're always asking yourself, 'Is there a better way to do it?'"

Do outpatients have access to the care they need?

At Stamford (CT) Hospital, **Trish Babcock**, RN, director of case management, is using inpatient case managers as outpatient coordinators for disease-specific populations, including patients with congestive heart failure and diabetes. "What we anticipate doing is looking at utilization issues in terms of accessing care — for example, getting home care as needed," Babcock says. "We want to close the loop in terms of follow-up issues with an outpatient clinic population, because clearly there are situations where there is incorrect utilization. We want to make a more seamless transition for the clinic population from the inpatient setting and be able to provide follow-up care." Stamford's case management coordinators will focus mainly on keeping patients

healthy by facilitating their access to services in the community, Babcock adds.

At Sonora, a small rural hospital with a total bed availability of 73, Kohler's two nurse case managers perform utilization review, social services screening, and discharge planning. Their average caseload can run as high as 16 to 20 cases per day, and they perform 100% review on all cases. While the hospital's payer base mix remains slanted toward Medicare, the market is steadily shifting toward commercial third-party payers — a trend that's creating some problems as the hospital seeks to expand its case management responsibilities. "Our third-party payers each tend to think that they have to create their own utilization review," Kohler says. "I aggressively work with the payers to encourage them to work jointly with us and not make utilization review such a duplicative process. That's an ongoing, daily effort."

Against that background, Kohler's case managers are assigned to patients by physicians, and lists are distributed to physicians' offices, units, and outpatient clinics. "That way, everyone knows which case manager to call," she says. "If it's Dr. A's case and the patient is in the emergency department, then the people there know that Karen is the case manager."

In addition, Sonora has compiled a manual of policies and procedures that cross departments, a step that has fostered a less compartmentalized approach to care. "We've now broken down the walls," Kohler says. "We're writing policies to include all other departments and address how we all interface together, including outpatient services. We all use the same manual and the same referral resource list. Whether you're going into your physician's office or clinic or coming to the hospital, the manual's everywhere."

KEY POINTS

- With the current national trend toward fully integrated health care systems, hospital-based case managers are becoming crucial to the expansion of acute care facilities into the outpatient arena. While many may still be getting used to juggling both clinical and financial duties, others — particularly at small, rural hospitals — are taking on even more responsibilities.
- While there are advantages to having inpatient case managers oversee outpatient and community care — including shortening inpatient length of stay in some cases — most inpatient/outpatient models have drawbacks as well. In particular, case managers are required to maintain a flexible outlook that encompasses the entire continuum, rather than just one slice of it.
- One potential result of the trend toward outpatient case management could be an increased willingness on the part of managed care organizations to subcontract work with hospital-based case management departments to handle outpatient programs.

CMs do preadmission discharge planning

This physician-based approach has been particularly helpful, Kohler says, because it's provided greater continuity in how cases are managed. It's also helped shorten inpatient length of stay. Case managers often go to the physicians' offices to do preadmission screening for some elective procedures. During that process, they also perform preadmission discharge planning. "Then you're not doing [discharge planning] on the inpatient side," Kohler says. "You're just checking to see if everything's the same. So, you've shifted your hours to before the admission."

But the physician-based approach has created some difficulties, too, by forcing case managers to shuttle between different care settings. "We have a big campus, with a lot of physician offices," Kohler says. "We also go to the emergency department to meet with patients, as well as to the outpatient clinics."

Given the average number of cases her case managers have to deal with, Kohler is attempting to come up with a flexible staffing schedule that factors in case complexity. Patients with a higher degree of severity would be assigned a higher point value, and if a case manager's total caseload exceeded a certain number of points (based on number of patients as well as severity), an additional case manager would be brought in to handle the overflow.

"It's challenging, because we have only two people doing this, with me as a back-up," Kohler says. "If one of my nurses is in a physician's office for two hours working on admission prevention and looking at placement issues outside of the hospital setting, then I'm out doing her work on

the floor. So, you need to have some flexible management leadership to make this work."

Referrals are coordinated with social services, and cases that involve primarily psychosocial issues are turned over to social workers. The social worker coordinates discharge planning and social services for an affiliated long-term care facility.

"Some nurses who say they're case managers don't do very well in this kind of setting. Not everyone can change hats so easily. It can be especially difficult for the real purists of utilization review."

Kohler acknowledges that her model requires case managers with highly developed skills and an ability to shift easily among a variety of roles. "Some nurses who say they're case managers don't do very well in this kind of setting," she says. "Not everyone can change hats so easily. It can be especially difficult for the real purists of utilization review to expand their thoughts beyond just looking at the cost and the setting and the quality to look at the entire continuum. To me, a good case manager is looking at everything almost at once."

Meanwhile, at Clinton Memorial Hospital, a small facility in Wilmington, OH, a new inpatient case management department is seeking out ways to partner with the hospital's existing outpatient case managers to develop cross-continuum pathways, says **Bonnie Davis**, RNC, CRNI, BSN, manager of Clinton's outpatient case management program.

Clinton's home health division has had both a case management department and a pathway program for years, but within the acute care setting, it was left to the social service department to perform basic case management duties.

Essentially, social services would make the initial referral for home care and ensure that the outpatient case managers received the proper paperwork. "But beyond that, there was no follow-up to see that we actually did go see the patient or how the patient was doing," Davis says. "They would just evaluate the patient as an inpatient, and when the patient was discharged, they were done with him."

In the outpatient setting, each of the four case managers is assigned to a geographical area and manages a caseload of 25 to 30 cases each. Two part-time visiting nurses provide backup when the case managers themselves can't perform visits. In addition to seeing the patient, the case manager coordinates referrals to home health, physical or occupational therapy, or any other necessary service. "She also continues to coordinate the chart and the patient's care, and oversees a community resource referral," Davis adds.

Case managers keep patients straight by using a color-coded system of travel folders, along with an area map that locates individual patients by the use of colored push-pins. "So, if a visit nurse sees that she has a red folder on her desk, then she knows who the nurse is," says **Sheila Hawley**, MSN, RN, clinical coordinator at Clinton.

Davis and Hawley have both been involved in the development of Clinton's new inpatient case management program, which they hope will integrate smoothly with their own efforts to establish a seamless continuum. The inpatient case managers will be assigned to a physician group and will follow up on patients even after discharge, Davis says. "It may just be a follow-up phone call, but they'll make sure that the patient's needs are being met. Our main goal is that we'll have proper and timely discharge planning and referrals to the proper community resources."

One thing Kohler hopes will come out of the trend toward outpatient case management is the establishment of more productive relationships with managed care companies. "I would like to see payers become a little smarter and understand that they can subcontract work with hospital case managers to run these types of programs in a way that provides cost-effective quality care," she says.

For more information about outpatient case management, contact the following:

Trish Babcock, RN, director of case management, Stamford Hospital, 128 Strawberry Hill Ave., Stamford, CT 06904. Telephone: (203) 353-2000.

Bonnie Davis, RNC, CRNI, BSN, manager, Clinton Memorial Hospital Home Health, Wilmington, OH. Telephone: (937) 382-6611.

Patricia Kohler, CPHQ, CCM, RN, director of utilization management, social services and discharge planning, Sonora (CA) Community Hospital. Telephone: (209) 532-3161. ■

Community-based model cuts use, boosts savings

(Editor's note: ***Lisa M. Zerull****, MSN, RN, is the program director for case management at Valley Health System in Winchester, VA. Nationally recognized for her innovative work in developing Winchester Medical System's community-based case management program, Ms. Zerull will be a featured speaker at next month's Hospital Case Management Conference in Atlanta. This month, she shares with* Hospital Case Management *readers the basics of her "outside the walls" approach to patient care.)*

Q: How did case management develop at Winchester Medical Center?

A: We've had acute care-based case management since 1988 or 1989. Around 1992, our acute care case managers began to identify what we call "frequent fliers." These were folks with diagnoses of congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes, or depression, for instance, who kept coming back again and again through the revolving door into acute care. Our emergency department also had quite a few "revolving door" patients and were looking for a better way to manage them.

[After reviewing the literature], it occurred to me that we should have a nurse going in the homes, interacting with the patient, targeting patterns of health care utilization and self-care management, to see what kind of a difference we could make. So we did a six-month pilot and case-managed 18 patients in the community. In that pilot, we showed a cost avoidance of $80,000.

Also, on the qualitative side, patients were telling us, "Now I know when to call my doctor and when to go to the hospital. I know what my precrisis symptoms are, so I know when to get help to avoid a full-blown crisis admission." Those comments were reflected in the data and in what we've seen for the past seven years. Length of stay and emergency department usage have decreased for our client caseload. And, if they are admitted, it's usually a direct admit, bypassing critical care days and with a shorter length of stay.

So, all the way around, [a community model lets you] decrease utilization while having patients who are more confident that they can manage their CHF or COPD. They know somebody cares about them, they know what to do, and they're empowered to make good decisions in regard to their health. And we're benefiting from that in a cost-saving sense.

Our challenge has always been that we're less than 5% managed care, with about 40% Medicare. People often ask us why we're trying to reduce admissions. They say, "Don't you make your money through patient admissions and hospital days?" And the answer is yes, but when you look at our large Medicare population, for which we receive a capitated reimbursement, it makes sense to keep them out, or — if they have to come in — to keep them within a reasonable length of stay.

Q: What sort of orientation was necessary to train your community-based case managers?

A: We have three full-time community case managers, and their peers serve as their preceptors. We try to get them out of the episodic mindset that most acute care nurses have. Many nurses are taught to operate in a medical model where the physician order pretty much drives the care they provide to patients. In community case management, it's more of a hands-off nursing. The most invasive thing we might do is a blood pressure reading or a pulse oximeter.

It's about looking at patterns, interacting with patients and asking them what is their definition of health: "If I could do two things for you to make you a healthier person, what would those things be?" Then we would target those community agencies and referral sources that might facilitate that person's health and wellness.

Community case management is all about interaction—the inter-relational aspect of care rather than interventional.

Q: Do you plan to further expand your community case management program?

A: We've often batted about the idea of integrating community case management with home health. Wouldn't that make sense, because we refer patients back and forth? In some smaller health systems in places like Iowa and North Dakota, some of my peers actually wear two hats.

I don't know where expansion's going to go, but I do believe that the future is the community, that more and more care is going to happen up front before the individual patient has acute care episodes. And our job is to make those smooth transitions from community to acute care and then from acute care back into the community.

For more information, contact Lisa M. Zerull, MSN, RN, program director, case management, Valley Health System, Winchester, VA. Telephone: (540) 665-5344. ■

GUEST COLUMN

Small hospitals benefit from program investments

But you must consider managed care goals first

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

Stanford (CA) University Medical Center reportedly spent $21,350 to develop a knee replacement surgery pathway.[1] Case management specialists suggest one case manager is needed for every surgical patient, whereas one case manager is needed for every 15 to 18 medical patients.[2] It is obvious that reducing the costs of hospital care is going to take some up-front expenditures!

While large facilities may have sufficient discretionary income to absorb these costs, what about smaller hospitals with very tight budgets? In addition, larger facilities are more likely to get a return on their pathway or case management investment just because of sheer numbers.

KEY POINTS

- Hospitals with fewer than 100 beds may find it challenging to get a return on clinical paths or case management program investments. That is why it so important to consider the hospital's managed care goals before embarking on the development of any program designed to improve care coordination.
- To achieve these goals, the small hospital has several different action plan choices, including: improve preadmission planning, more closely monitor the appropriateness of admissions and continued stays, expand discharge planning, design preprinted physicians' orders or protocols, expand community health services, and expand community-based case management.
- Most importantly, involvement is needed from physicians, managers, and staff who "own" the clinical process involved.

Stanford reported an approximate savings of $3,000 per case after the knee replacement pathway was implemented. For Stanford, that savings quickly offset the cost of pathway development because of their large number of admissions for knee replacement surgery.

What about the small hospital at which far fewer surgical procedures are performed each year? The financial gain may be slow in coming.

Hospitals with fewer than 100 beds may find it challenging to get a return on clinical paths or case management program investments. With the low numbers of patients in each diagnostic / procedural category, the hospital's ability to obtain a significant financial and quality return on investment is questionable. That is why it so important to consider the hospital's managed care goals before embarking on development of any program designed to improve care coordination. Administrative and medical staff leadership at small hospitals must carefully consider what they hope to achieve from a resource management and performance improvement perspective. The goals should be expressed in measurable terms. **(For examples of goals a small hospital might seek to achieve from care management activities, see box, p. 46.)**.

To achieve these goals, the small hospital has several different action plan choices: improve preadmission planning; more closely monitor appropriateness of admissions and continued stays; expand discharge planning; implement case management; institute stop orders for high-cost tests / treatments; design preprinted physicians' orders or protocols; expand community health services; expand community-based case management; give physicians round-the-clock access to discharge planning / social services support; design and implement clinical paths with input from physicians and other clinicians involved in patient care; and so on.

Small hospitals should explore all of their resource management options and select the least costly initiatives that are most likely to achieve goals. For example, if the goal is to "Decrease overall cost of care for congestive heart failure patients by 10%," first determine where costs are highest. The hospital may find that the most effective way to reduce costs is to have the nurse manager of the critical care unit conduct daily rounds to encourage triage of patients to a step-down unit as soon as they are clinically stable. Another goal might be: "Improve the clinical care provided to patients with congestive failure." This goal is best achieved through development of "point-of-care"

Resource Management Goals

1. Reduce length of stay in high-volume surgical DRGs for Medicare/Medicaid/indigent patients by two days within one year.
2. Reduce length of stay in high volume medical DRGs for Medicare/Medicaid/Indigent patients by three days within one year.
3. Reduce clinical laboratory and radiology utilization by 25% within two years.
4. By the end of one year, ensure all inpatients are seen by the discharge planner or have a discharge plan designed by staff nurse at least 24 hours prior to their discharge.
5. Within the next six months, identify respite care needs of the community and develop appropriate action plan.
6. Within six months, reduce denials from third-party payers for inappropriate admissions and unnecessary continued stays by 50%.
7. Reduce the percent of asthma patients readmitted within 45 days by 75% within two years.
8. Within the next six months, improve by 20% the advancement of medications from parenteral to oral route when patients are able to tolerate oral intake.
9. Within one year, reduce by 25% the number of unnecessary pre-op days of hospitalization.

reminder tools (e.g., clinical pathways, preprinted standing physician orders, treatment protocols).

Most important, involvement and commitment is needed from physicians, managers, and staff who "own" the clinical processes involved. The owners of the process must have ownership of the choice of tactics, the implementation, and eventual analyses of the results.

• Start with data.

Administrative and medical staff leaders, as well as all clinical caregivers, should understand where the hospital is failing to meet its managed care objectives and why meeting these goals is important. Use data to substantiate the value of whatever initiative may have been proposed. Caregivers must appreciate the benefits of paths, case management, or any care coordination tactic. If new patient management initiatives are viewed by caregivers as "make work" additions, clinicians' endorsements will be difficult to secure.

• Explore universal paths.

Because of the low number of patients in any one diagnosis or procedure category, small hospitals may wish to explore the development of "generic" paths. These paths are applicable to a larger group of patients because they are not specific to one diagnosis-related group. The path in the accompanying pathway **(see p. 47)** covers the care provided to all patients in the ambulatory care unit who receive general anesthesia. While each patient may have slightly differing care needs, there may be enough similarities to allow development of a universal path such as this. Slight variations of this path can be designed for patients having local, epidural, or block anesthesia. Universal paths also can be developed for inpatients whose care patterns are similar.

• Involve all providers.

Small hospitals must work closely with pre- and post-hospital providers to develop care coordination initiatives that cover an entire episode of care. For surgical patients, involve physicians' clinic nurses to determine patients' preoperative care requirements. When designing pathways or initiating case management for high-risk patients, be sure to collaborate with home care agencies, nursing facilities, public health nurses, community mental health agencies, and other out-of-hospital caregivers. Not only will the hospital get a better return on its care coordination investment, but patient and community satisfaction also will be enhanced by reducing fragmented care.

• Concentrate on a few high-risk patient groups.

When developing condition-specific pathways or choosing patients for case management interventions, start with patient populations that include more than 150 admissions per year. Target populations do not need to be diagnosis-specific. For example, case management services may be initiated for patients meeting the following criteria:

— requires assistance with activities of daily living;

— is a caregiver for someone else;

— has had three or more hospitalizations last year;

— is admitted from another facility (hospital or skilled facility);

— is receiving home care services;

— has a serious memory loss;

— has a history of repeated falls in the past year.

Many small hospitals are finding that five clinical pathways for high-volume diagnoses, a few generic paths, and case management for select high-risk patients meeting criteria such as those listed above are sufficient to achieve their resource management goals.

(Continued on page 48)

Ambulatory Surgery Pathway

Intervention		Phone Call/Pre-Admission	Pre-Op/Day of Surgery	Surgery	PACU	Phase 2/Recovery	Discharge/FU PC
Assessments		Obtain admission assessment. Sign consent.	----> ---->	Review admission assessment.	----> On admission, in 10 min., and every 15 min. until discharge. - Resp. status - Level of consciousness - CMST - Cardiac rhythm and rate - N&V - Dressing and drains - Vital signs	----> In 30 min., every hour x 2, and PRN ----> ----> ----> ----> ----> ---->	 ----> ----> ----> ---->
Consults	Medical H&P P.T. when applicable	---->					
Tests/Procedures		Pre-op per standard/verify results	---->				
Nutrition			NPO		Sips as tolerated	Liquids as tolerated	---->
Medication		Current meds and allergies	Pre-op meds as ordered	Administer intra-op meds.	Post-op meds as ordered.	---->	
Activity/Safety		Up as PTA	----> If sedated, up with assist. If sedated, side rails up.	Safety measures: straps, positioning, padding, normothermia, pre/post-op counts. Correct grounding pad placement. Correct tourniquet placement.	Siderails up Padding and/or restraints PRN Normothermia	Falls precaution Ambulate with assist or as PTA	----> ---->
Treatments			VS on admission Glucose monitoring or ordered Antiembolism device as ordered IV as ordered	----> ----> ----> ----> Prep as ordered Foley as ordered	 ----> ----> ----> ----> Respiratory care as ordered Pulse oximetry Dressing change and/or reinforcement Ice packs as ordered. Drain care. I&O PRN Elevation PRN		

Source: Spath P. *Clinical Pathways for Perioperative Practice.* Santa Fe, NM: OR Manager; 1998. Pathway developed by Mercy Medical Center, Mercy Oakwood Medical Center, Oshkosh, WI.

With careful planning, small hospitals can ensure a return on their resource management investment. Many small hospitals throughout the United States have successfully integrated paths, case management, and select utilization management interventions into their overall patient care strategy. If you want to succeed, don't use the cookie-cutter approach. Carefully select affordable interventions that are most likely to be accepted by caregivers and achieve your resource management goals.

References

1. Macario A, Horne M, Goodman S, et al. The effect of a perioperative clinical pathway for knee replacement surgery on hospital costs. *Anesth Analg* 1998; 86:978-84.

2. Newell M. *Using Nursing Case Management to Improve Health Outcomes.* Gaithersburg, MD: Aspen Publications; 1996, p. 33. ■

KEY POINTS

- A joint replacement pathway developed at DuBois (PA) Regional Medical Center has made fans out of patients and orthopedic surgeons alike, thanks to its extremely flexible approach, which accommodates all the varying practice patterns of the referring physicians.
- The pathway's designer, himself a physician, devised the pathway to be so flexible because he realized that the orthopedic physicians would never be persuaded to standardize their practice patterns.
- Even with the designer's attempts at accommodation, many orthopedic physicians held off endorsing the pathway until patients began sharing their enthusiasm for it. The pathway has served as a useful training tool for young physical therapists.

Flexible rehab path wins wide physician support

Plan popular with physicians, therapists, patients

A joint replacement pathway developed at DuBois (PA) Regional Medical Center has achieved high levels of physician and staff support by building in a radical degree of flexibility to accommodate different physician practice patterns.

The combination knee and hip replacement pathway, designed for patients without medical complications who have single joints replaced, combines all the common aspects for total hip replacement and total knee replacement patients. But it also contains a section that allows physicians to check off specific treatments for each diagnosis and the preferences of the orthopedic surgeon. **(See sample page from the pathway, p. 53.)**

Given the physician-friendly nature of the pathway, it's not surprising that it was spearheaded by a medical director, **Martin A. Schaeffer**, MD, a physiatrist in the department of physical medicine and rehabilitation at DuBois. Schaeffer knew the pathway couldn't succeed without the support of the orthopedic surgeons, or orthopods, because they would be responsible for referring the patients to the pathway program.

But accommodating the orthopods proved to be tricky, because each one had a slightly different approach to caring for joint replacement patients. "Basically, the pathway standardizes the treatment of patients once they're on the rehab unit," Schaeffer says. Prior to that, the orthopod can elect not to put the patient on the pathway and has full autonomy regarding surgical techniques and when the patient should be placed on the rehab unit. Even though the pathway takes effect on the unit, it remains flexible enough to satisfy individual physician preferences.

For example, Schaeffer notes that each orthopod favors slightly different settings for the Continuous Passive Motion (CPM) machine. "That's okay. We know that for a knee, everyone is going to get a CPM," he says. "But we also know that for Dr. X's patient, the setting will be zero to 75 the first day, whereas with Dr. P, the setting will start at zero to 110 the first day. We have those kinds of special adaptations."

The difficulty was building in enough flexibility to satisfy the orthopods while still having a pathway that therapists and nurses could make sense of. "We can tell the patients, this is what you're going to do, yet have it be flexible enough so that we can incorporate individual treatments," he says. "Because, essentially, there would be no way that I could convince three orthopods that

(Continued on page 54)

CRITICAL PATH NETWORK™

Total knee arthroplasty clinical pathway

By **Kati Harlan**, RN
Anne Meiring, LCSW
Shands at AGH
Gainesville, FL

Clinical pathways have taken a firm hold in our health care industry as an intervention to improve efficiency, reduce costs, and improve outcomes of care. The two major forces driving the development of these pathways are federal reform measures (which include encouragement of more standardization of care) and the pressures of managing costs under capitated payment. Another important reason to institute clinical pathways is that they demonstrate interdisciplinary collaboration to the regulatory agencies. To address these major pressures, Shands at AGH, a community-based hospital of 402 beds and a member of the Shands Healthcare system in Gainesville, FL, began its own focus on clinical pathways.

Like many others, we define clinical pathways as practice guidelines developed by a multidisciplinary team for a specific patient population — a progression of care for a typical patient type. Expected interventions for nurses, physicians, and other key disciplines involved in the care are listed, timing and sequencing of care are identified, and an expected length of stay is assigned. Day-to-day activities such as consultations, tests, treatments, medications, diet, activity, teaching, and discharge planning are identified and scheduled on the appropriate day to reduce redundancy and variation in practice patterns.

The Shands at AGH team was approached to assist in development of a pathway for total knee arthroplasty (TKA) patients. The chief of staff, an orthopedic surgeon who was president of his orthopedic practice, approached the quality resource management department to request its assistance in developing a pathway for total knee replacement patients. The goals of the pathway were to improve the transition from preadmission through discharge for this population.

Concurrently, a total reorganization of the quality resource management (QRM) department was occurring, and a QRM Steering Committee was formed with its initial task before it: Respond to the request for the initiation of a total knee path. This aided in selection of QRM Steering Committee members, so that ultimately the team included the rehabilitation services director, orthopedic medical surgical nursing director, performance improvement facilitator, QRM director, nursing vice president, and the medical director of QRM. This team's collaboration with the orthopedic surgery group helped drive the success of this process.

The committee had fortuitously included the orthopedic group office manager, who was invaluable in assisting with the development of preadmission process design to facilitate preoperative assessment and teaching. The preadmission process already had existed for total knee and hip patients; however, it was inefficient and underutilized. This article will provide some tools we have developed to assist others in considering the development of their own pathways, from the preadmission process through discharge.

These tools include:

- a sample clinical pathway with a focus on the rehabilitation portion to demonstrate the concurrent variance tracking tool;
- a fax form to identify the surgical date and information data which is used to assist in planning for preadmission teaching;

(Continued on page 52)

The Clinical Pathway is a general guideline. Patient care continues to require individualization based on patient needs and requirements.

SHANDS at AGH

CLINICAL PATHWAY **TITLE: TOTAL KNEE ARTHROPLASTY**

SERVICE/MD:_____

ALLERGIES: _____

•Note all allergies and check to ensure patient receives no medication allergic to. Call MD to obtain alternative medications.

***VEO**: Variance from Expected Outcome*

CARE ELEMENT	Pre-Op Evaluation DATE:	Pre-Op Admit Day - Day of Surgery DATE:	Post-Op Admit Day of Stay DATE:
CARE UNIT		Admit as inpatient Meds/trtmt/activity as follows:	PACU / Orthopedic Nursing Unit
CONSULTS	•Participation in pre-op eval (rehab therapy & case manager) [ ] yes [ ] no •Nursing for pre-op teaching and assessment		
DIAGNOSTICS	•CBC •Urinalysis •Basis or comprehensive metabolic panel •CXR as ordered •PT of pt. on Coumadin (or as ordered) •EKG •Oxygen sat baseline - FAX to surgeon's office •Other labs as ordered	•Assure that blood is available as ordered; for autologous donor, draw STAT type and screen on admission	•HCT prn in PACU and as ordered •Knee x-ray as ordered
MEDICATIONS	•Stop NSAIDs, Ticlid, & Persantine per protocol	•Kefzol 2 gm. IV 15-30 min. prior to incision in OR - document time given on MAR for next dose • Pre-op meds and IV per anesthesia	•Kefzol 1 gm IV q8h X 3 more dose •Lactated Ringers as ordered •Other meds as ordered
PAIN & SYMPTOM CONTROL			•Laxatives as ordered •Epidural as ordered •Antiemetics per order •Pain meds as ordered
TREATMENTS	•Instruct pt. to shower with 4 oz Hibiclens the evening before surgery	•Overhead trapeze on bed in PACU •Prep as ordered •Send one pair of pneumatic stockings to OR with patient •IV in holding area as ordered •Insert foley catheter in OR	•Turn, cough, deep breathe, IS q 2 h while awake x 72 hrs. •Measure hemovac drainage q shift •I & O q 8 hrs •Bed in prevent mode •No pillow under operative knee •Do not flex operative knee •Knee immobilizer as ordered •Follow heel protocol •CPM placed in Recovery Room 0-60 as tolerated •Overhead trapeze placed on ortho bed •Heel Protocol
ASSESSMENTS		•Vital signs as ordered •Pre-op checklist completed	•Assess drssg. immediately post-op then q4h - follow Orthopedic Dressing Protocol •Check motor & sensory/other per orders
NUTRITION	•NPO after MN night before surgery	•NPO	•NPO then •Diet as ordered

Source: Shands at AGH, Gainesville, FL.

CARE ELEMENT	Pre-Op Evaluation DATE:	Pre-Op Admit Day - Day of Surgery DATE:	Post-Op Admit Day of Stay DATE:
ACTIVITY	•	•	•
CASE MANAGEMENT	• Review options for post-acute rehab; explain ins. coverage. • [ ] HHC • [ ] Outpt. rehabilitation • [ ] Inpt. rehabilitation:__ 7W, Subacute; ___ other SNF [pts. 1st choice:_____ 2nd choice:_____) • [ ] Potential DME needed:_____ DME already owned:_____ • Family available to assist after acute stay:_____ • Pt's. preferred post-acute rehab plan:_____		
REHAB THERAPY		**VEO Codes:** **PC01: pt. condition:pain** **PC02: pt. condition:nausea** **PC03: pt. condition:vomiting** **PC04: pt. condition:refuses** **PC05: pt. condition:fatigue** **CL01: clinician decision** **MD01: physician decision** **OTH01: other (pls. specify)**	• Place pre-op eval in chart • Education: no oob w/o assistance; no pillow under knee; disable knee gatch on bed Att:_____ Var#_____ • CPM placed in recovery rm 0-60 degs or as tolerated Att:_____ Var. #_____
EDUCATION	• TKA Booklet • Patient Pathway	• Patient pathway • Reinforce instructions to pt. on use of PCA pump	• Patient education flow sheet per Rehab Therapy
OUTCOMES	• Knowledge deficit related to surgical proc.- the pt. will express understanding of pre/post-op events & expectations • Change in level of function after D/C-potential needs will be discussed & options will be offered for the pts. D/C planning	• Resources will be identified and the need for potential svcs. will be noted on the nrsg. admission assessment	• The pt. will express understanding of post-op events & expectations • Continue evaluation • Verbal or non-verbal expression of comfort with the use of parenteral or PO analgesics • Altered immobility related to surgical proc.=pt. verbalized effects of immobility, maintains full ROM in unaffected extremity
Signature /Initials	•	•	•
	•	•	•
	•	•	•
	•	•	•
	•	•	•
	•	•	•
	•	•	•
	•	•	•
	•	•	•
	•	•	•
	•	•	•
	•	•	•

Source: Shands at AGH, Gainesville, FL.

(Continued from page 49)

• preadmission and admission orders (completed in the physician's office prior to the patient's hospital presentation);

• a sample of specific protocols embedded within the preprinted orders/guidelines.

The results of the implementation of the TKA pathway at Shands at AGH already have been seen, and it is hoped the pathway might serve as a marketing tool in future negotiations with managed care companies.

It was to our advantage that total knee patients were the population we were first asked to address under our QRM Steering Committee initiatives. The TKA population has been well-documented in the literature as a best stepping stone for initiating clinical pathways into an acute care setting. The reasons include the ability to monitor specific benchmarks or milestone guidelines, such as the initiation of physical therapy and the cessation of intravenous pain medication.

Our major accomplishment to date has been the strengthening of preoperative assessment and teaching by both rehabilitation and case management for the total knee and hip patients. While this program already was in place for these patients, it was selectively utilized by only a small portion of our orthopedic physicians.

Education of the physicians, as well as their office staff, and implementation of a collaborative process to identify the candidates for this service at the time of surgical scheduling has resulted in an increase to virtually 100% compliance for this indicator. Development of additional tools is under way to further improve and optimize the consistency of care that our TKA population receives from us. ■

Total Knee Arthroplasty
POST-OP ORDERS
Only Those Orders Checked (X) Will Be Followed:

Date:_____

Time:_____

( ) 1. Operation: Total Knee Arthroplasty ( ) right ( ) left
( ) 2. Condition: ( ) satisfactory ( )_____
( ) 3. Allergy: ( ) none ( )_____
( ) 4. Vital Signs: per PACU protocol, then q _____h
( ) 5. Check motor, sensory, and color in toes with each VS x 48 hrs.
( ) 6. Record intake and output
( ) 7. Foley to gravity drainage
( ) 8. Diet: ( ) NPO ( ) Clear liquids until nausea subsides
( ) Advance as tolerated to regular diet
( ) Other _____
( ) 9. Activity: Bedrest (BRP yes/no); to bedside chair _____
( ) Keep _____elevated at all times
( ) WBAT ( ) NWB on_____ ( ) PWB on_____
( ) 10. IV: ( ) Lactated Ringers @ _____cc/hr.
( ) Convert to heplock when taking adequate PO fluids
( ) D/C after last dose of _____
( ) 11. Meds:
( ) Kefzol 1 gm IV q 8 h X 3 more doses
( ) Demerol _____mg PO or IM q _____h PRN pain
( ) Phenergan _____mg IM q _____ h PRN nausea or with Demerol PRN severe pain
( ) PCA pump; see separate PCA orders
( ) Epidural; see separate epidural orders per anesthesia
( ) Ortho Bowel Routine:
1. Laxative of patient's choice prn. If no patient preference, MOM 30cc po and repeat prn.
2. If no BM by 48 hours post-op ***and*** laxative not effective after 12 hrs., may give Fleets enema.

SEE PAGE 2 OF POST-OP ORDERS
AFTER ORDER IS WRITTEN, remove yellow copy and send to Pharmacy. After yellow sheet is removed, "X" out remaining lines above.

Source: Shands at AGH, Gainesville, FL.

REHAB CLINCPATH-1
sharing\crcipath\rehab\clncpth1.pub 1/22/97
Revised: #1 8/27/97sag

CHART COPY - THIS COPY MUST REMAIN IN CHART
DUBOIS REGIONAL MEDICAL CENTER
DUBOIS, PENNSYLVANIA

CLINICAL PATHWAY PHYSICIAN'S ORDER

AUTHORIZATION IS GIVEN TO THE PHARMACY TO DISPENSE AND TO THE NURSE TO ADMINISTER THE GENERIC OR CHEMICAL EQUIVALENT WHEN THE DRUG IS FILLED BY THE PHARMACY OF DUBOIS REGIONAL MEDICAL CENTER - UNLESS THE PRODUCT NAME IS CIRCLED.

IMPRINT PATIENT'S PLATE HERE

PATHWAY NAME: Single Total Joint Replacement for Hip or Knee
PROVISIONAL DIAGNOSIS:
ALLERGIES

DATE/TIME	ORDERS: CHECK ALL THAT APPLY	Other
	Initiate Clinical Pathway Physician Orders	
	Admit to the Rehabilitation Center of DRMC Servise of: _____	
	Diagnosis: _____	
	_____ Single Total Joint Replacement Critical Pathway	
	_____ Knee _____ Hip	
	Condition: Stable	
	Activities: Out of Bed with Assistance Only	
	Vitals: per Routine	
_____	NKDA	
_____	Allergies	
_____	Diet: _____	
_____	EKG _____ New _____ Copy of previous report to current chart	
_____	UA _____ UC&S	
_____	Labs:	
_____	Profile G _____CBC _____ Renal Profile _____ Mg	
_____	PT _____ PTT _____ Lytes	
_____	Other: _____	
	_____	
_____	Incentive Spirometry q shift	
_____	Trapeze to Bed	
	Medications:	
	PLACE AN "X" BEFORE THE ORDER TO BE CARRIED OUT	

NURSE'S SIGNATURE _____ PHYSICIAN'S SIGNATURE _____

(Continued from page 48)

they should all start doing their DVT [deep vein thrombosis] prophylaxis the same."

Even with Schaeffer's attempts to accommodate the orthopedic surgeons' autonomy, many still took a wait-and-see approach to the pathway, at least at first. Soon, however, it became apparent that patients were enthusiastic about the pathway and were in fact telling their orthopods how they felt. "The patients told them they really liked it, the care was good, they got out on time, and their leg was fine. So the orthopods kept sending us patients," Schaeffer says. "We had to assure them we were going to incorporate what they wanted and we weren't going to tell them what to do. Of course, that's what a lot of physicians normally don't like about pathways."

Breaking eight days into four segments

Instead of listing activities and goals day by day, Schaeffer decided to create a range that could accommodate variations in patients' activity and motivation. The eight-day pathway is broken into four segments: days 1-2; days 3-4; days 5-6; and days 7-8. This allows more motivated and functional patients to progress faster and be discharged earlier.

Because of the flexibility in days, staff are able to accelerate a patient's progress on the pathway. For example, if the therapy evaluations show that a patient is on a high functional level, staff have the option of combining the activities on days 1-2 with the activities on days 3-4.

Most patients are discharged by day 7, although the pathway goes through day 8. Patients who stay a day longer are likely to have been admitted on a Friday. DuBois offers limited therapy on weekends. Because of the option for an accelerated pathway, some patients have been discharged as early as day 4 or 5 if they have met all the goals for day 8, Schaeffer says.

The document has fit so well with the needs of the patients and clinicians that it's undergone only one minor change since the rehab unit started using it in January 1997. **(For details on how the pathway was developed, see related article, this page.)**

In addition to being accepted by orthopods and patients, the pathway has won over referring physicians because it allows them to plan patient discharges. The pathway also makes it easier for the rehab hospital to plan admissions and discharges because it sets out the length of stay for these patients. The young therapy staff also are happy with the pathway because it sets out exactly what patients are supposed to do and when, Schaeffer says.

There hadn't been a rehab unit in the area, so rehabilitation as a specialty was very unfamiliar. Some of the therapists had experience in outpatient treatment but no inpatient experience, Schaeffer says.

"Because we are a relatively young rehab unit, we have a very young therapy staff. We found that some therapists actually were looking for specific expectations of therapy. The pathway tells them what is expected on each day, and they like that," Schaeffer says.

For example, seasoned therapists know from experience how much joint replacement patients should be able to walk, but the therapists who were just out of school had some uncertainties, Schaeffer says.

"When it was open-ended, these therapists would work with the patients, but they didn't know what goals to set for each day. The pathway eliminated that problem," Schaeffer says.

For more information on DuBois Regional Medical Center's critical pathway for joint replacement patients, contact Martin A. Schaeffer, MD, medical director, department of physical medicine and rehabilitation, DuBois Regional Medical Center, Suite 300, 145 Hospital Ave., DuBois, PA 15801. Telephone: (814) 375-4660. Fax: (814)375-5206. ■

Critical pathway is a combination of ideas

Other providers, surgeons, therapists had input

The joint replacement critical pathway being used by the rehab unit at DuBois (PA) Regional Medical Center is a combination of pathways from other providers, preferences of referring orthopedic surgeons, and input from the staff.

The effort was spearheaded by **Martin Schaeffer**, MD, medical director for the department of physical medicine and rehabilitation.

(Continued on page 59)

AMBULATORY CARE
QUARTERLY

Create cost analysis to see if your staffing is adequate

Expert gives tips on starting from scratch

With all of the proposed changes to Medicare regulations for outpatient centers, it might be time to conduct an analysis of your facility's staffing requirements.

Staffing is one of your biggest expenses. If you need to consider some cost cuts, now is a good time to make sure the number of employees is adequate but not excessive.

Though every facility will have its own needs, there are some general guidelines to follow, says **Vicki B. Sullivan**, RN, CNOR, director of surgical services for Quad City Ambulatory Surgery Center in Moline, IL. Quad City is a freestanding physician-owned center that performs approximately 150 procedures a month. Sullivan's experience includes developing an ambulatory surgery center (ASC) from the ground up.

"Staffing is one of the most difficult things to develop in a surgical center because surgical volume is not consistent," she says. Sullivan offers these guidelines to developing staff for a new center, or expanding or reducing staff at an existing facility:

1. Determine staffing needs.

First, consider the center's size by answering these questions:

- How many operating rooms are there?
- Do you have a minor procedure room that is used at the same time as the operating rooms?
- How are these rooms scheduled? "When our facility utilized a second room, I looked at the amount of time I anticipated using that room, and we had to almost double the staff," Sullivan says.
- What is the facility's physical layout? Sullivan says the physical layout could decrease or increase staff hours. For example, staff in preoperative and recovery areas might be able to assist each other if the two areas are adjacent. "The design of our center enables staff to have visual access to all these areas," she says.

Second, outline the procedures and services your facility provides. For example, an ASC usually needs staff in the areas of surgery scheduling, preoperative assessment and patient education, admission, operating suite, and recovery rooms. Whether these areas are staffed by RNs, LPNs, or other health care workers depends on the facility's policy.

Last, the staffing requirements depend on the center's goals and desired outcomes. If a center chooses to be accredited by a governing body, then the staffing levels should be raised to meet those standards. Also, the state's licensing requirements may dictate a staff-to-patient ratio in recovery areas.

2. What kinds of skilled staff are needed?

Sullivan charted the types of staff necessary for her facility by drawing two simple diagrams. One demonstrates the staff needed for a single operating room. This includes a receptionist, a preoperative nurse, four operating room employees, one first-stage recovery nurse, and one second-stage recovery nurse. The facility may hire a nurse educator and employees to handle nonpatient responsibilities.

The second diagram lists the staff for two operating rooms where they could be shared. This staffing might include two preoperative nurses, six operating room employees, and two each of first- and second-stage recovery nurses. All employees, except the preoperative nurse, could be used to assist and relieve their counterparts in the second operating room.

After completing the diagrams, Sullivan wrote the staffing requirements in terms of full-time equivalents (FTEs). For example, the preoperative RN position in a single operating room is written out as 1 FTE. She added up the total to arrive at a figure for the staff required in the facility.

3. Determine staffing costs.

Once you have the number of FTEs per position, you can easily figure out how much your

staffing needs will cost. First, use your actual average hourly wages for each discipline or an estimated hourly wage. Chart these in columns, entering the total hourly cost to the far right column. The bottom of the column will give the total average hourly cost.

Sullivan says it's probably a good idea to use FTEs instead of full-time and part-time positions when determining the total cost because full-time employees often change to part time or vice versa, and your ratio probably will not remain stable.

"I don't think there's any rule for a ratio of full time to part time. It depends on the qualifications of the people you employ and what their desires are," she says.

For more information on staffing an outpatient facility, contact Vicki B. Sullivan, RN, CNOR, director of surgical services, Quad City Ambulatory Surgery Center, 520 Valley View Drive, Moline, IL 61265. Telephone: (309) 762-1952. Fax: (309) 762-3642. ■

Get a handle on four major cost drivers

If you want to cut costs, try this method

The buzz words of outpatient facilities in the 1990s undoubtedly are "cutting costs." These two words could mean the difference between profit and loss for many outpatient facilities that are caught in the reimbursement crunch between managed care and Medicare.

The good news is that this may not be as difficult as you imagine. Outpatient surgery centers could measure and then cut the costs of any procedure by focusing on four cost drivers, says **Kathryn Barry**, senior director of health policy and reimbursement at United States Surgical Corp. in Norwalk, CT.

"Any health care provider doing ambulatory surgery needs to have a tool or methodology to capture the cost of the procedure because of the proposed reimbursement changes anticipated for ambulatory facilities," Barry says.

United States Surgical Corp. provides consulting services to health care providers, including its Best Practices program for procedural cost analysis. Barry and three other U.S. Surgical Corp. consultants describe the four cost drivers as follows:

• **Operating room time.**

Excess OR time can raise costs if patients or anesthesiologists are late or if there are delays in surgeons turning over the room for the next procedure, says **Randolph Williams**, MBA, director of health care strategies for U.S. Surgical in Manassas, VA.

One 10-minute delay could affect all of the other surgeries that day and cost the facility more money, Williams adds.

The solution is to identify what is causing these delays by reviewing surgery data. They might reveal that two surgeons consistently do this procedure on time, while others are consistently late, Williams says.

"All surgeons want more time in the OR, and if they're delayed by 15 minutes, they may not get in that last case of the day," Williams says.

So, the facility's managers should share these data with the surgeons. They should show them how much even five minutes of lateness in the OR costs the facility, says **Kyle Nelson**, MBA, manager of provider services for U.S. Surgical in Norwalk, CT.

• **Use of instruments.**

Efficient physicians might have a slightly higher instrument cost because they use disposable instruments, Barry says.

But those disposable instruments might be more cost-effective because they save time and perhaps even manpower in the operating room, says **Jeff Frum**, MBA, health care strategy director for U.S. Surgical in Trabuco Canyon, CA.

"Disposable instruments are a lot more efficient in the OR because there is no assembly or disassembly of parts," Frum says. "There's a lot of downtime in the OR assembling these instruments or finding back-up replacement parts."

• **Ancillary service ordering.**

This area includes pharmacy, laboratory tests, radiology, respiratory, cardiology, and other services provided to patients. Ancillary services might experience significant inflation over time because physicians tend to be generous in ordering additional lab tests and other services, Barry says.

"The lesson we've learned is if you look at ancillary services, you have a huge opportunity to streamline and reduce costs," Barry adds.

For example, she says, standard preoperative testing once included four or more diagnostic tests, and some physicians still call for that many. But the standards today say physicians need order no diagnostic tests if the patient is healthy and middle-aged.

Anesthesia costs are another example. A surgery center might find that one particular anesthesia agent is more expensive than others, but it saves money because the patient recovers more quickly. Thus, the length of stay is reduced, Nelson says.

• **Length of stay.**

Look at expanding your selection of procedures, and go after some traditional inpatient procedures, Barry suggests.

You also may reduce the lengths of stay by influencing patients' expectations up front, Williams says. "So, when you go into the physician office for the first time, you are given this road map of this procedure and what to expect," he says.

For example, the physician or case manager might tell the patient that if all goes well with this surgery and there are no complications, the patient will feel great and will want to go home within two hours after surgery, Frum says. This can have a significant impact on the patient's recovery time, he adds.

Another cause of delays in length of stay is a surgeon who is lax about discharge procedures. The surgeon might not get around to filing the discharge orders or seeing the patient as soon as possible, Frum says.

All of these cost drivers have become extremely important in today's health care environment, Williams says.

"Customers are struggling today with finding ways to stretch their savings beyond the price of a product," he observes. ■

Creative staffing ensures continuity of patient care

Aim is around-the-clock reinforcement of goals

When two rehab nursing aides decided to become therapy aides at Lourdes Regional Rehab Center in Camden, NJ, the supervisory staff realized there was a gap between nursing and therapy orientation and practice.

They found that instead of helping the patients learn to do for themselves, as is the case in therapy, the former nursing aides were working with patients from a nursing perspective in which they had to do everything quickly.

"There is a gap between what our nursing assistants learn and do in the nursing environment, where they need to do things quickly, and on the therapy floor, where they assist the therapists with two patients an hour," reports **Tammy Feuer**, MA, CCC, administrator of rehabilitation and postacute services.

On the nursing floor, for instance, when all patients are getting up and dressed at the same time, speed may become an issue that takes priority over therapeutic goals. So, instead of helping patients ambulate or dress themselves with assistance, the aides tend to do it for them.

That's why the hospital administration has looked at ways to make sure the therapy goals are reinforced by all staff, even on weekends and evenings.

Having both therapy and nursing aides helps

"As patients become more medically acute, nurses become so involved in medical care that they don't have time for rehab nursing techniques. We are trying to find efficient ways to carry out mobility and activities of daily living goals on the nursing unit," Feuer says.

The hospital has therapy aides who assist on the therapy floor weekdays and nursing aides who assist on the nursing floor around the clock, seven days a week. Physical therapy and occupational therapy students from local schools work as therapy aides on weekends.

The hospital originally set out to cross-train aides to work as both therapy aides and nursing aides. "We want our people to be flexible so they can go to the area of greatest need, but more than flexibility, [that need] is to achieve carry-over of therapy goals on the nursing unit," Feuer says.

However, they ran into some resistance when therapy aides balked at working on weekends and saw nursing assistants as doing more toileting than ambulating. "We backed off for a while. It's still a good concept, and we still are looking at how to carry it out," she says.

Here are a few ways the hospital is working to increase communication between shifts:

• **Changes in shift times.** In the past, the therapy aides worked 8 a.m. to 4 p.m., and the nursing aides changed shifts at 7 a.m., 3 p.m., and 11 p.m.

The nursing aide shifts were changed to run from 8 a.m. to 4 p.m., 4 p.m. to midnight, and midnight to 8 a.m. The move will make it easier to rotate aides between therapy and nursing on

weekdays. In addition, it will help with the nursing shift changes because the aides remain on shift during the nursing report and are available to answer lights and attend to patient needs.

• **Evening rehab nursing tech.** A staff member who has worked both as a nurse's aide and as a therapy aide now works from 4:30 p.m. until 9:30 p.m. Monday through Saturday. She's not counted in the nursing care numbers, but she is an additional employee whose primary function is to carry out therapy goals. For example, she works with activities of daily living during dinner, helps patients with adaptive devices in the shower, and helps them work on their undressing techniques at bedtime.

"Her primary focus is to work with the occupational therapy and physical therapy plan of care," Feuer says.

Sunday nights are more family-oriented and patients don't shower, so there isn't the need for the extra help with showers and other activities of daily living, she says. The evening rehab tech is training the nursing aides to help the patients meet their therapy goals.

• **Extra staff during crunch times.** The rehab tech is on hand for dinner, showers, and undressing Monday through Saturday. The day shift nursing aides arrive an extra half-hour before the night shift leaves, which gives double coverage for the morning crunch time.

At Lourdes, the regular staff work eight hours with a half-hour meal break and get paid for 7½ hours. The day aides work 8½ hours and are paid for eight.

"It's not a big increase in patient care hours, but it makes a big difference because we have extra hands when we need them," Feuer says.

• **One-on-one training in transferring patients.** When a patient who needs moderate or greater assistance is admitted to the nursing unit, a therapist trains a nurse and an aide on the day and evening shift on how to transfer the patient. The goal is to have the nurses trained on transferring the patient within 24 hours of admission.

When nurses transfer patients, they strive to do it quickly. When therapists transfer patients, they concentrate on making sure it is done accurately and with the functionality of the patients in mind.

The hospital has always had an orientation session in which the therapists demonstrated how to transfer each kind of patient. The new method makes it more meaningful because the nurses learn what is needed with each individual patient. "It's a patient they know and can ask questions. It really means something, as opposed to the first days of orientation, when they don't know the patients," Feuer says.

Nurses may use two or three staff for a difficult transfer, but the therapist may be able to do it alone. "It's possible that this training will help with efficiency, too," she adds.

The training also gives therapists a chance to observe what kinds of problems the nursing staff encounter when they transfer patients, and it allows therapists to solve problems on the patient floors.

Feuer says she hopes an added benefit will be a reduction in workers' compensation injuries because the nurses will learn firsthand how to transfer a patient safely. Traditionally, the nursing units have experienced far more back injuries than the therapy units, she says. ■

Simple talk gets message across to CHF patients

The best way to deliver information about congestive heart failure (CHF) management is to talk in bullets, says **Glynis J. Laing**, PhD, RN, CNAA, disease manager for heart failure at MetroHealth Medical Center in Cleveland.

"I skip the elaborate explanations about the circulatory system," she notes. "I tell patients that their hearts simply aren't pumping right, and then I give them the four main components of CHF management."

The components are as follows:

• **Medication compliance.** "I simply tell patients they must take their medication every day just the way the doctor told them to take it."

• **Low-salt diet.** "We don't get really nervous about salt since the patients are on diuretics. I don't expect them to count milligrams. I just tell them to put the salt shaker away and use frozen or fresh foods more often than canned or boxed foods."

• **Exercise as tolerated.** "If patients can walk, I tell them to start walking around their house. Once they feel comfortable walking around the house, I tell them to start walking around the yard, then eventually around the block."

• **Daily weights.** "I skip weight ranges," she says. "I tell them if your weight is 167, call your doctor. They simply could not grasp the concept of a weight range." ■

(Continued from page 54)

Before he started development of a critical pathway for hip and knee replacement patients, Schaeffer collected as many orthopedic pathways as he could from other hospitals. He also used materials provided by HealthSouth Corp. Managed Services, a division of HealthSouth Corp. in Birmingham, AL, which manages acute inpatient rehabilitation units. "I took the best from each one and was able to draw up a pathway that incorporates the individuality of our orthopedic surgeons," he says.

Most of the pathways Schaeffer studied were longer than the one he came up with, and most providers had separate pathways for hip replacement and knee replacement patients.

Schaeffer began developing the pathway by meeting separately with each orthopedic surgeon and finding out his or her preferences for treating their patients in the rehab unit. Among the questions he asked were:

- what settings they preferred for the continuous passive motion device following knee surgery;
- what their deep venous thrombosis precautions were for hip surgery patients;
- what kind of dressing their patients needed;
- when patients could take showers;
- whether they wanted their patients to use compression stockings.

Where common ground existed, Schaeffer incorporated it into the pathway for all knee or hip replacement patients. Other areas of the pathway are check-off boxes where individual physiatrists can indicate the protocols they want used with their patients.

An advisory team of staff from the rehab unit was set up to assist in drafting the pathway. Representatives of all disciplines reviewed the document and suggested changes. Instead of starting with a critical pathway in the early months of the rehab unit's existence, Schaeffer waited until staff became more familiar with the inpatient rehab process.

Hospital Case Management™ (ISSN# 1087-0652), including **Critical Path Network**™, is published monthly by American Health Consultants®, 3525 Piedmont Road, N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Case Management**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6:00 Mon.-Thurs.; 8:30-4:30 Fri. EST. E-mail: customerservice@ahcpub.com. World Wide Web: www.ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $369; approximately 18 nursing contact hours, $419; Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $295 per year; 10-20 additional copies, $221 per year. For more than 20 copies, contact customer service for special handling. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $62 each.(GST registration number R128870672.)

This continuing education offering is sponsored by American Health Consultants®, which is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, provider number CEP 10864, for approximately 18 contact hours.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@medec.com).
Executive Editor: **Susan Hasty**, (404) 262-5456, (susan.hasty@medec.com).
Managing Editor: **Paula Stephens**, (404) 262-5521, (paula.stephens@medec.com).
Associate Managing Editor: **Russ Underwood**, (803) 781-5153, (russ.underwood@medec.com).
Senior Production Editor: **Brent Winter**, (404) 262-5401.

Editorial Questions

For questions or comments, call **Russ Underwood** at (803) 781-5153.

"Since inpatient rehab was unknown to many on the staff, and nursing and therapists had never worked together, we had to educate staff first," he says. Schaeffer began discussion with the staff during the second year the rehab unit was open and developed the pathway over several months. ■

COMING IN FUTURE MONTHS

- Information technology supports case management efforts at Staten Island, NY, health system
- *Critical Path Network:* Cross-continuum CHF pathway cuts costs, mortality
- A two-part special report on the ethics of hospital-based case management
- Pathways for ischemic stroke and lung volume reduction

NEWS BRIEFS

M&R claims 53% of Medicare days are avoidable

Milliman & Robertson's latest Hospital Efficiency Index claims that more than half of all inpatient days for Medicare patients are avoidable. Further, the index, which compares national average lengths of hospital stay and admissions to benchmarks achieved by top hospitals, concludes that average length of stay for all Medicare patients could be reduced from 6.6 to 4.1 days and admissions could be reduced by 38% if hospitals operated more efficiently. The report adds that, if care were provided outside the hospital, 16% of all admissions could be avoided.

According to the index, states with the most efficient hospitals include Oregon, Utah, and Washington. The least efficient is Mississippi. ▼

Study finds seniors unhappy with choices

In a study of more than 200 Medicare health maintenance organizations (HMOs) and more than 1,200 Medicare supplemental insurance policies in 19 cities nationwide, *Consumer Reports* magazine found that seniors are facing higher out-of-pocket expenses for health care, cutbacks in HMO benefits such as prescription drugs and vision care, and a burdensome array of Medicare choices.

The study's key findings include:

• Premiums are up 35% on average since 1994 for Medicare supplemental insurance, which offers seniors the greatest flexibility of doctors and hospitals.

• Premiums for Medicare Part B will more than double over the next eight years, from $526 this year to $1,172 in 2006.

• Premiums for Plan C, the most popular of the 10 standard Medicare supplemental plans, are up 41% since 1994.

• Many seniors who signed up with a Medicare HMO because it paid for prescription drugs are finding their plans now limit or have begun to charge for this benefit.

A worksheet that helps consumers to evaluate the prescription drug benefits offered by different HMOs is available in the September *Consumer Reports* as part of the magazine's special report, "Medicare: New choices, new worries." An interactive version is available on the magazine's Web site at www.ConsumerReports.org. ■

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. ■