AMERICAN HEALTH CONSULTANTS

HOSPITAL CASE MANAGEMENT™

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

IN THIS ISSUE

JANUARY 2003

VOL. 11, NO. 1 (pages 1-16)

Old hat or cutting edge? The state of the art of clinical pathways

Interdisciplinary approach important for modern pathways

Every year, *Hospital Case Management*'s reader survey asks case managers what they like most and least about the newsletter. And every year, readers variously compliment and criticize us for the extent to which we cover clinical pathways.

The diversity of responses and the strength of case managers' feelings about pathways aren't necessarily surprising. Even though clinical pathways first were developed more than a decade ago, some hospitals only now are implementing them, while other facilities have been using them for years and are moving on to a new generation of automated case management tools. So what is the state of the art? Are clinical pathways old hat or cutting edge? And if you aren't using pathways, what *are* you using?

Karen Zander, RN, MS, CMAC, FAAN, who pioneered clinical pathways at New England Medical Center in Boston in the 1980s, says the same forces that initially created interest in pathways are in play today. They include:

- changes in economics in health care;
- initiatives and regulations for quality improvement and best practice from an expanding body of evidence;
- the desire for automation of the health care record;
- the search for better ways to involve patients, families, and partners.

She adds that clinical pathways are one of the few tools that can combine content and action. "A guideline is a content tool. It doesn't record action; it just tells you the content," says Zander, now principal and co-owner of the Center for Case Management in South Natick, MA. "An algorithm is a content tool. A clinical path, in some organizations, is a content tool when it's used as a reference. If it then crosses over into being part of the medical record and replaces things like progress notes and treatment sheets, then it becomes an action tool."

How pathways are used at different facilities depends, in part, on the facility's level of commitment to moving beyond content tools, she adds. "It's a huge decision, a high-maintenance decision. As soon as you start to try to structure content into action tools, you are tying yourself to a high-maintenance strategy where you have to keep refreshing the content and reworking the format of the action tools; and then ultimately, you're going to be driven to having to get a computer. It's an interesting quandary: Are we just going to consider content; or are we going to make a tool where we really have to do something with that content and have roles, expectations, policies, and procedures upon the use of that content with patients?"

Toni Cesta, PhD, RN, director of case management at Saint Vincents Hospital and Medical Center in New York City, says it's important to take an interdisciplinary approach to pathways, in part, because of the expectations of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in Oakbrook Terrace, IL. "The Joint Commission is looking for interdisciplinary care plans, but also interdisciplinary patient problems and expected outcomes," she says.

Some early tools focused on tasks without including associated outcomes or interdisciplinary patient problems, Cesta explains. They tended to be brief and idiosyncratic to the particular organization at which they were developed. Then a second generation emerged, emphasizing outcomes and interdisciplinary plans. "But now what we're really looking for are interdisciplinary patient problems and outcomes together," she says. "Also, people are starting to think more about incorporating documentation into the tools themselves with the outcomes."

Newer tools are attempting to incorporate medical interventions with other disciplines' interventions and expected outcomes, "sort of melding all of that together into one set of problems and outcomes," Cesta adds. "That's the challenge of what everyone's struggling to do right now. It's the third generation, in a way."

Another important development for clinical pathways has been the incorporation of "evidence-based medicine," in the form of best-practice indicators, Zander says. "Doctors like best-practice indicators," she says. "They will talk to you about indicators. They won't talk to you about paths. But if they sign off on the indicators, you can start building paths from them. You can build order sets."

Physicians' positive response to evidence-based indicators could represent an opportunity to revive a moribund pathway program, Zander adds.

"It's a really good chance to revisit them, but don't go in with a blank piece of paper," she says. "Go in with a set of researched indicators." *(For more information on clinical indicators, see the Center for Case Management's web site at cfmc.com.)*

Alamance Regional Medical Center in Burlington, NC, has been using clinical pathways since

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. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Case Management**™, P.O. Box 740059, Atlanta, GA 30374.

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Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6 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), $429. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $343 per year; 10-20 additional copies, $257 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 one month of the missing issue date. **Back issues**, when available, are $72 each. (GST registration number R128870672.)

Editorial Questions

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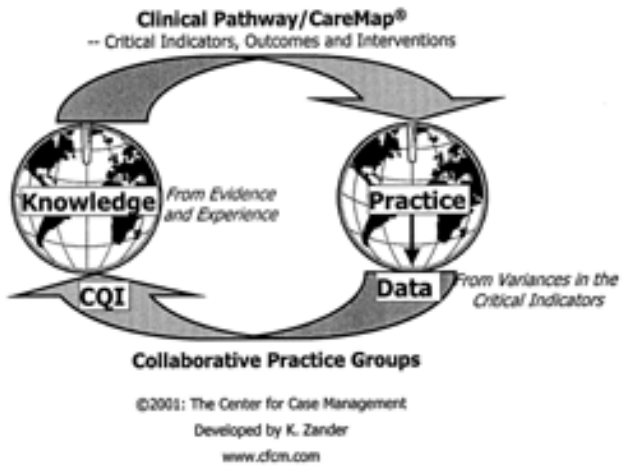
How Practice Improves



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1994 and recently implemented an automated component. **Brenda S. Holland**, MSN, RN, CareWays coordinator at Alamance, says the facility's successful group of pathways has evolved steadily over the years, based on a number of factors, including clinical research, length of stay, and cost factors.

"We're looking now at JCAHO indicators, and of course, those are integrated into the CareWays," Holland says. "So we try to link those with our cost-analysis system here and look at other hospitals as to how well they're doing."

Holland is satisfied with the outcomes Alamance has achieved using pathways, most notably its overall length of stay. She adds that pathways can represent "a very good learning experience, and they are very useful when the nurses look at the care plans. One nurse can go from one unit to another unit, just pick it up, and see what needs to be done for the patient. I think they will be even more user-friendly once we get them automated and can get some more concrete data that we can look at other hospitals with."

Alamance may be ahead of the curve in terms of adding automation to its pathway program. In her consulting work, Cesta says she still doesn't see much computerization of pathways or other case management tools. "Obviously, the Internet is helping us in terms of getting clinical information to put into the tools themselves," she says. "But as far as them being available on-line and in hospitals to use and document against, I have not seen a lot of that. There aren't that many case management departments I have visited that even have any kind of automated system at all."

Whether your pathways are automated or not, it's important to have a policy that outlines how frequently you review them, Cesta says. "Usually, it should be annually or biannually that they are reassessed for currency. The literature should be re-reviewed at that time, and the content should be brought up to date if it's not representing the state of the art at that point in time. People shouldn't just sit back after they've developed these kinds of tools. It really should be an ongoing process — almost a part of your CQI [continuous quality improvement] process."

Such continual updating is important because the clinical literature changes. "The state of the art changes. The medications recommended for particular diagnoses change over time," Cesta says. "So it's really important that [pathways] are kept up to date because they do represent the organization's standard of care for the management of that diagnosis or surgical procedure. If they're not as current as possible, you're putting yourself in a liability situation should there be a problem. How do you defend a tool that's out of date?"

[At the 2003 Hospital Case Management *Conference, to be held April 27-29 in Atlanta, Cesta will present a pre-conference one hour session for case managers: "Integrating Prospective Payment and Managed Care Reimbursement Systems with Case Management" (1 hour), and "The Case Manager in the Hospital Setting: Role Functions and Model Design" (1 hour). Cesta also will present a post-conference session. For more information or to register, call (800) 688-2421.]* ■

Comparative performance data can be change agent

Identify and correct 'near fatal flaws'

One of the major challenges facing case managers is what to consider when selecting comparative performance data. But that is just the first of several questions that must be addressed, says **Patrice Spath**, BA, RHIT, a consultant in health care quality with Brown-Spath & Associates in Forest Grove, OR. It also is important to identify and correct serious flaws in utilization and outcome data, she adds.

Deborah Hale, president of Administrative Consultant Service in Shawnee, OK, says case managers then must learn how to create data presentations that answer common questions posed

by physicians and administrative leaders. One key to success will be understanding why comparative data may not motivate physicians and other caregivers to action and how to change that, she points out. Another is what to do after you've captured people's attention with the data.

According to Spath, the following questions are a good starting point for organizations to use when investigating comparative measurement options. It's important to keep in mind that no one system is likely to meet *all* of these performance measurement requirements, she says.

Here are eight questions that can help begin the assessment:

1. Are the measures standardized at the national level? Do all organizations participating in the system report the same kind of data in the same way?
2. Are the measures adjusted for factors that could make your organization's performance appear better or worse than it really is (e.g., patient age, gender, health status, severity of illness)?
3. What resources will your organization need to gather the data?
4. Will the measurement results be available in time for you to produce and distribute reports within a reasonable time following the end of the reporting period?
5. Have the measures been tested adequately to ensure that they consistently and accurately reflect the performance they are intended to measure?
6. Are you confident that the measures reflect actual performance and not shortcomings in the data and/or information systems?
7. Will the measurement results allow your organization to identify significant differences in performance as compared to other organizations with similar characteristics?
8. Does the performance system include an audit or quality-control function to ensure reliability of the measurement results?

In addition, each system should be evaluated based on its ability to meet the clinical information needs of its physicians and professional staff, as well as its ability to support its strategic performance improvement goals, Spath says.

The next step is to identify and correct near fatal flaws in utilization and outcome data, Hale says. "It is a 'near fatal flaw' in the outcomes data if we are not accurately reporting the diagnoses and the procedures that were performed for the patient. That requires comprehensive physician documentation as well as coding accuracy."

This can be the most significant flaw in utilization and outcome data, she adds. "I have also seen any number of hospitals use mortality data indicating that they had a much higher than expected mortality rate." In those cases, investigating the problem often reveals that they were in the wrong DRG, she points out. When the DRG assignment is corrected, data typically fall within expected parameters.

As case managers prepare the data presentation, they must be certain to trace that back to the medical records and know the data are accurate based on accurate DRG assignments, Hale says. "You want presentations that draw clear pictures." That means avoiding spreadsheets or any very complex graphic display, she says. "I have found that physicians and administrative leaders do the best with very simple graphics that illustrate one or two points. It is best when they are colorful and very easy to read."

Another important consideration for case managers is why comparative data may not motivate physicians and other caregivers to action and what steps can be taken to change that. "Data quality is more than accuracy and reliability." Spath adds that high levels of data quality are achieved when information is valid for the use to which it is applied, and when decision makers have confidence in the data and rely upon them. "Data-based decisions must be made with confidence, at least confidence in the data," she explains. The final criterion upon which to judge the quality of data is whether decision-makers who rely upon the data have confidence in them, she explains.

Spath says case managers can help people feel confident in the quality of the data through two key steps. The first is to confirm as much as possible the accuracy and reliability of the data in the information system before preparing reports. The second is to know the questions that will be asked or the decisions that are to be made to ensure that the right data are presented and the appropriate analyses are conducted.

Beyond the more "mechanical" levels of data quality, she says it is important to keep the goal in the mind. "The true test of data quality is whether the information is useful, usable, and used for decision making," she asserts.

Hale says the last step in this process is to meet with a select group of physicians and staff who comprise a performance improvement team to examine not only financial data but clinical information as well. That includes high mortality rates and high potentially avoidable complication rates.

"These are the other things in the data that raise questions rather than answering them," she adds.

Once that presentation is completed, Hale says case managers must examine the processes to determine what needs to be improved. These teams must "take apart the data," brainstorm, and hypothesize why the data look the way they do, she says. According to Hale, that means case managers must determine what the key performance measures are that must be captured from chart review. "You never want to collect more data in chart review than you think you might use," she cautions.

At that point, the team can begin to develop solutions using quality improvement principles. They may decide that a way to improve the overall performance is as straightforward as education for the staff, developing protocols, or redesigning the process, Hale says. "The important thing is that people with ownership in the diagnosis of the procedure in question determine what the strategies and procedures are."

The team may find very high costs for managing a particular diagnosis, but the care is consistent with professionally recognized standards of care and no improvements can be made. However, in most instances there is at least some opportunity for improvement including the chance to educate physicians, she says.

The team becomes the framework for disseminating information and developing improvement strategies, Hale says. "The thing that most people overlook is that they do not follow through by evaluating the effectiveness of the action that they have taken," she says. "They may have even made the situation worse. If they don't go back and collect data and re-measure, they will never know." They will also have nothing to celebrate, Hale adds.

[Spath and Hale will conduct a presentation, "Using Comparative Performance Data as a Catalyst for Positive Change" at the 2003 Hospital Case Management Conference, to be held April 27-29 in Atlanta. For more information about the conference or to register, call (800) 688-2421.

In From Quality to Excellence: Using Comparative Data to Improve Health Care Performance*, a new book by Patrice Spath and Aggie Stewart, quality managers and health care practitioners can learn how to incorporate comparative measurement data into their organization's quality and patient safety improvement strategies.*

The book includes examples of comparative data from many sources and sites of patient care and a discussion of relevant regulatory and accreditation requirements. Readers learn how JCAHO and Medicare surveyors interpret comparative data and what is expected when the organization's performance varies significantly from other facilities.

For more on From Quality to Excellence*, call (503) 357-9185 or visit www.brownspath.com. A complete table of contents for this book is available on the product page of the web site.]* ■

CMSA overhauls case management standards

Standards reflect patient-centered approach

The Case Management Society of America (CMSA) in Little Rock, AR, has revised its Standards of Practice to reflect changes in the health care system and the evolving role of case managers within that system. **(See *Hospital Case Management*, Dec. 2002, p. 192.)**

Because those changes have been so profound since the standards originally were developed in 1995, the revision can more accurately be characterized as a major overhaul, says **Kathleen Moreo**, RN, Cm, BSN, BPSHSA, CCM, CDMS, CEAC, who co-chaired the Standards of Practice Task Force with **Gerri Lamb**, PhD, RN, FAAN.

According to Moreo, CMSA's board of directors identified the need for updates in the standards based on emerging trends and changes in the industry such as the growth of managed care and changing demographic trends as well as changes in case manager staffing issues.

Another important issue is the Health Insurance Portability and Accountability Act (HIPAA). The standards, however, are designed to serve as a guideline for the professional practice of case managers rather than a direct response to those new mandates, Moreo says.

"HIPAA is one component of what the case manager has to do in terms of both legal and ethical performance in his or her job," she explains.

There is a section of the standards of practice that addresses consent and patient security in general terms. "It is not applicable strictly to HIPAA but rather appropriate guidelines to be able to practice professionally," she says.

Moreo says the most significant change in

focus in the new standards is that they move case management to a more patient-centered approach.

"If you look at the old model under the standards of practice, it had the client and the case manager together in the center and the continuum of care surrounding that," she says. "In the new model, the patient is the center of care."

The new standards also move away from what Moreo calls an insurance focus. "The 1995 standards were very insurance-driven." She says that was because the model of case management at the time was based on payers and independent case managers. "We tried to change the focus and embrace the hospital case manager." CMSA also decided the new standards should be more outcomes driven, with an emphasis on evidence-based practice.

To make sure that the standards reflected the range of disciplines and the expanded settings, CMSA sought representation from as many of the key case management settings as possible, Moreo says. The new standards expand the range of settings to be more representative of where case managers now are practicing. That includes case managers who work in long-term care, those who work directly with consumers, and those who work in the public sector.

Another important area that was added is cultural competence. "We didn't even address cultural competence in the 1995 standards," Moreo says. The new standards give that area its own section. "We thought cultural competence is reflective of the kinds of caseloads that we are experiencing and the kinds of situations that were coming across in our everyday working environment," she explains.

The new standards also address population-based care instead of only individualized case management. According to Moreo, the 1995 standards focused on costs while the new standards shift the focus to care. "It is care delivery vs. cost efficiency," she says.

The 1995 standards also talked a lot about resource utilization, she adds. Now the emphasis is on resource management and stewardship. "Stewardship is what we hear in the hospital setting, in particular with hospital-based case management," she reports.

"Case managers are not performing resource utilization but rather stewardship." Those standards of practice also recommended specific levels of education and certification. The new standards acknowledge the educational levels of individuals as well as certification but do not make recommendations. "We didn't feel that was the role of the standards," Moreo says. "The standards are not supposed to police people but rather serve as professional guidelines."

According to Moreo, the CMSA standards are the predominant standards for case management in part because the association was developed as a multidisciplinary professional association.

"CMSA is not married to any one discipline or practice setting," she asserts. "They speak to the importance of certification but are not aligned with any single certification."

She notes, however, that the Commission for Case Manager Certification in Rolling Meadows, IL, has legally adopted the standards. "When you become certified, you have an ethical and legal responsibility to adhere to the CMSA standards of practice," she says.

Moreo adds that it is important for hospital case managers and acute-care coordinators to know where the 1995 standards may have fallen short in identifying guidelines for professional practice by the hospital-based case manager. "I think they will find the 2002 standards to be very embracing of acute-care case management," she predicts.

According to Moreo, the current model of hospital case management was just beginning to emerge in 1995, and there were struggles taking place between social workers and nurses.

"Departments were being put together just to be blown apart and restructured again," she recalls. "There was a lot of volatility in hospital-based case management.

Today, she says that model has "settled in" and is gaining momentum. "That's why we thought it was important to make sure that we took the emphasis off the payer setting and add an emphasis on acute-care and post-acute care settings," she says.

Moreo says the process put into place to develop the standards was extremely comprehensive. The task force was multidisciplinary in terms of licenses and certifications as well as practice areas. "We also made every effort to get these draft standards out throughout the industry and beyond," she reports.

Making the standards as relevant as possible is critical, she concludes. "The new standards are something case managers can really get their arms around and say: 'Yes, this pertains to what I do and pertains to the challenges that I might have on any given day.'" ■

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'Everybody wins' as CM, home health join forces

Looming JCAHO survey prompts affiliation

A couple of years ago, **Lisa Zerull,** RN, MS, the force behind the dramatically successful community nurse case management (CNCM) program at Valley Health System in Winchester, VA, faced a new challenge: She was informed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) that it would begin surveying the program based on the agency's home care standards, in conjunction with the health system's home health program.

"In the past, JCAHO hadn't really looked at us," she says, adding she believes that may be the case with other, similar programs that simply aren't on the accrediting body's radar screen.

Not wanting to reinvent the wheel, Zerull went to Valley Health's home health director and said, "How can we work with you to ensure a good survey?" Drawing on the policies and procedures and performance improvement process developed by director Patty Klinefelter during her 16 years in home health, Zerull says, "I just molded [them] to fit our program."

The home health program, Zerull notes, has received perfect scores in its two most recent JCAHO surveys.

Collaboration began with dialogue

The successful collaboration between the two entities, which for years had operated separately, began a discussion that ultimately led to a joining of forces, Zerull says, although that didn't happen immediately.

"We started a dialogue, with the thought that we have so much to share, the opportunity to educate both sides on what we do," she notes.

"But in the initial dialogue, there were some turf issues." Home health personnel had the perception that the CNCM were caring for patients who should have been under home health and were in effect providing free care for those patients, she says.

Finally, Zerull adds, "I said, 'OK, why don't you screen, do the intake, and tell us who we can care for?'

Because the two programs constituted "home and health services," it made sense to have one telephone number for physicians, emergency department clinicians, or hospital case managers to call to arrange care for their patients, she says.

Referrals to CNCM

"We drew upon one another's expertise to come up with a plan that worked for both sides. It was better for home health to handle the central intake process to assure that the appropriate level of community care was being offered," Zerull adds.

The central intake system began in October 2000, Zerull notes, and JCAHO surveyed the programs in March 2001. The joint score was 99, she says, adding with a laugh that the point subtracted "was not because of us." It had to do with the incorrect labeling of a bag being used in home-administered chemotherapy.

With the advent of the central intake process, she notes, the percentage of patients referred to CNCM by way of home health has gone from 6% to 80%.

When the patient's condition doesn't meet home health criteria, he or she can be referred to the CNCM program, Zerull explains. "Home health is the acute model, and we're the subacute model. We're just valuing the level of care that each [program] brings."

The CNCM nurses "do nothing invasive," she

adds. "The only two instances where we obtain a physician order is if we're filling a pillbox and for pulse oximetry."

As patients' care needs change, they may be traded back and forth between the two programs, Zerull notes.

"[Home health] may follow a patient for six weeks and then refer the patient to us. We may see them for three or four months and then they're in the hospital and once again qualify for home health."

Future plans include having one nurse who can wear both hats, which would enhance the continuity of care, she says. "Relationship is one of the greatest predictors of wellness. If you have a socially isolated 80-year-old who is now dealing with a chronic illness, one of the bright spots in her life is that visit from a nurse case manager."

The idea is problematic from an administrative standpoint, however, Zerull says. The CNCM nurses see their patients a maximum of once a week, and those visits are scheduled according to geographic area, she adds.

If a patient now needs to be seen three times a week, the nurse could find him- or herself driving back and forth between locations far removed from each other, Zerull says.

Physicians benefit

Combining the two programs has had many benefits, she points out. In addition to increased staff and patient satisfaction, physicians enjoy the advantage of being able to call only one telephone number or make one referral to arrange patient care, Zerull adds.

She was warned early on to "keep [the CNCM program] away from home health because it will confuse physicians," she says, but Valley Health staff take steps to make sure that is not a problem.

"We educate them that when they write the order for home care, they write 'home and community services' and we determine the best level of care. Everybody wins with this solution."

The home health program now can make use of a CNCM innovation whereby the computer system flags the names of patients who are admitted to the hospital, Zerull notes. "We get an automatic e-mail [regarding the admission], and we don't make a wasted visit."

The affiliation also has made possible a contingency staffing plan, she says. When one of the CNCM nurses was dealing with the possibility

Outcomes

Indicator	Pre-CNCM	Post-CNCM
# Hospital Admissions	499	219
Avg. LOS	16	10
# ED Visits	70	48
# Critical Care Days	67	20

N = 182

Source: Lisa Zerull, Valley Health System, Winchester, VA.

CNCM Good Economic Sense

Salary, Benefits	$55,000
Travel Reimb.	$ 4,000
Supplies	$ 4,000
Misc.	$ 2,000
TOTAL	**$65,000**

Based on 1.0 FTE

Source: Lisa Zerull, Valley Health System, Winchester, VA.

One High-Cost Patient

Hospital $ Loss/Admission *DRG 127– CHF*	$20,000
Avg. 5 Admissions/Year (5 x $20,000 =)	**$100,000**
TOTAL HOSPITAL COSTS	

*Avg. Caseload- 35 patients

Source: Lisa Zerull, Valley Health System, Winchester, VA.

of taking time off to have open-heart surgery, "[home health] had nurses who could fill in," Zerull adds. "Before, we were it. We had to cover our own time."

Promoting the 'wellness mindset'

Valley Health's CNCM program began in 1992, when Zerull's job was to coordinate acute-care case management, she says.

"The 16 case managers from the hospitals would come together as a team and say, 'We're great at mobilizing patients through the system and doing discharge planning, but the chronic care patients keep coming back into the system.'"

Using as a model a Tucson, AZ, program that since has disbanded due to lack of funding, Zerull put together a proposal for CNCM and, to justify it, gathered data on patients who were high users of the system but weren't homebound and so didn't meet home health criteria.

After the program was in place, figures showed, and continue to show, around a 50% reduction in emergency department (ED) visits, length of stay (LOS), and critical-care days, she says.

The CNCM program has continued to save money for Valley Health, a two-hospital system with a rural, tri-state service area, she says.

Each year, outcomes illustrate that the cost of seven to 10 home visits equals the cost of just one day's hospital stay, Zerull says, not to mention the improvement in patients' quality of life.

Looking at an actual patient known as "Joe," for example, records show that after participation in the CNCM program, the number of annual hospital admissions went from five to one, with average LOS reduced from 12 days to four days, she explains.

The cost of Joe's care went from about $120,000 to about $12,000. Noncompliant before, the patient now closely follows the prescribed regimen of care, including medications, diet, and exercise, Zerull adds.

Then there is the more intangible result of Joe changing from a "sick mindset" to the perception of a higher level of wellness, she says.

Despite such successes, Zerull reports little progress in her effort to have the Centers for Medicare & Medicaid Services — then known as HCFA — answer the question posed in the July 2000 issue of *Discharge Planning Advisor*: What if there were eight years of data (now 10 years of data) illustrating that it's cheaper to pay per visit for community nursing care for the chronically ill than to pay for periodic acute care episodes at the hospital — and that patient outcomes are better, too?

Because programs such as Valley Health's CNCM save money rather than make money, she points out, they probably will not get much support from chief executive officers.

If the nation's hospital CEOs "can see the benefit of keeping people out of the hospital," the dynamics of health care can change, Zerull adds. "It's a prevention mindset vs. an illness/treatment mindset."

If a chronically ill patient is in and out of the hospital, she says, "we're saying that it's too expensive to use critical care days. With Medicare, you get a set rate reimbursement, by DRG. That means, for example, for congestive heart failure, you're getting $6,300, no matter how long the patient stays in the hospital."

To continue with the example of the chronic patient named Joe, Zerull explains, "If Joe comes in, is put on a ventilator, has four or five critical care days, and then goes home in 12 days, the system has to absorb the cost of care for anything over that $6,000."

The aim of the CNCM program is to teach such patients to go to the physician's office or the ED before they're in crisis, she adds, so that hospital stay might only be four days.

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Solutions needed for prescription drug problem

Making sure patients without an insurance plan for prescription drugs get the medications they need is an increasing challenge, case managers and discharge planners tell *Discharge Planning Advisor*.

Faced with a high-cost list of prescribed medications, "patients decide to take only some of the drugs or maybe some of the doses or none at all," says **Tina Davis**, RN, MS, CMAC, senior director for continuum of care at Arnot Ogden Medical Center in Elmira, NY.

"This can lead to readmission to the hospital," Davis points out.

Contributing to the problem is some physicians' tendency to prescribe "the latest and the greatest," which can cost much more than "the tried and true," she adds.

Case managers who are aware of the issue may try to put patients in touch with pharmaceutical companies that provide no-cost drugs to needy individuals, Davis notes, but sometimes it takes six weeks to obtain the medications.

Lisa Zerull, RN, MS, the program director for the Community Nurse Case Management Program at Valley Health System in Winchester, VA, points out that the philanthropic programs sponsored by drug companies all require different processes and forms, and may include restrictions that can make it difficult to obtain the help.

For instance, Zerull adds, some require that for a patient to qualify, the drug company's local sales representative must call on that patient's physician.

"The prescription drug problem is a very hot issue," agrees **Jackie Birmingham**, RN, MS, CMAC, a longtime case manager who now is managing director for Curaspan Inc., in Needham, MA. "It's especially a problem for those who are on pain medications and have traveled a far distance to a center for surgery," she notes.

"Patient satisfaction is a huge issue when you are unable to [obtain] the medications to get them started until they can go to their own pharmacy to get the prescriptions filled. The patient needs to go home, and the family needs to leave them to go get the medications," Birmingham adds.

*(*Discharge Planning Advisor *will look at possible solutions to the various problems associated with obtaining prescription drugs for patients in future issues. Please send any feedback on the issue to Lila Moore at lilamoore@mindspring.com.)* ■

Final outpatient PPS rule increases spending

The 1,000-page final outpatient prospective payment system (OPPS) rule, which takes effect this month, provides the congressionally mandated inflationary update and increases overall spending, but still pays hospitals only 83 cents for every dollar spent on outpatient care, the Chicago-based American Hospital Association (AHA) points out.

The rule gives the mandated 3.5% increase, but the net effect of all provisions in the rule is a 3.1% increase from last year for urban hospitals and a 6.2% increase for rural hospitals, according to a report in the on-line service *AHA News Now*.

The rule does not include a pro-rata reduction in pass-through payments for certain new and high-cost devices, drugs, and biologicals. It lowers the outlier threshold from 3.5 to 2.75 times the ambulatory payment classification amount, enabling hospitals to reach the outlier threshold sooner. However, outlier reimbursement will drop from 50% to 45% of costs above the threshold amount. ■

Patient records linked as part of warning system

Twenty million ambulatory care patient records will be connected as part of an early warning system for terrorism-related illness outbreaks.

The Centers for Disease Control and Prevention (CDC) has awarded $1.2 million to the Harvard Consortium to develop and pilot the early warning system.

The project will create a computer operating system that can link information from various types of medical systems and health departments so health professionals receive early warning of a terrorism attack, the CDC announced.

The system would scan managed care networks continually for clusters of illness. If successful, the platform would serve as a model for a syndromic surveillance system that would be one element of a national warning system.

Consortium members include the American Association of Health Plans, Harvard Pilgrim Health Care, HealthPartners Research Foundation, and Kaiser Permanente of Colorado. For more information, go to www.cdc.gov. ■

How to know when you're facing an ethical dilemma

Consult supervisor, peers, CCMC for assistance

When you're confronted with an issue that just doesn't feel right, ask yourself: Am I truly doing the right thing at the right time for the right reason?

If the answer is yes, you're probably making an ethical decision, says **Mindy Owen**, RN, CRN, CCM chair of ethics committee and a member of the executive board of the Commission for Case Manager Certification (CCMC) in Rolling Meadows, IL.

In all cases, whether you're a nurse, a social worker, or a therapist, follow your professional scope of practice and professional code of conduct, Owen advises.

All case managers should take time to review the Code of Professional Conduct issued by the CCMC, suggests **Susan Gilpin**, JD, chief executive officer of the CCMC. "It's not designed to be a punitive weapon but a measure that gives case managers guidance when they face something that doesn't feel right," Gilpin says.

If there is any question about the scope of practice or code of conduct when case managers think they are being asked to overstep their bounds, they should start by raising the issue with their supervisors, Owen advises. Even if they don't get the answer that makes the situation feel right, if the issue arises in the future, they can say they consulted with their supervisor and were told to follow a certain direction, she adds.

Consult other certified case managers to see how they handled a similar situation.

"In the cases of ethical dilemmas, case managers often get their best help from peers who have faced the same question," Gilpin says.

Once case managers have reviewed their scope of practice within their work environment, if they still have questions, they should bring it to the commission for review, Owens says.

"It goes back to doing the right thing at the right time and for the right reason," she says.

The CCMC hasn't received a large numbers of complaints against case managers concerning ethical violations. However, the CCM does receive requests for advisory opinions from case managers in the field who aren't sure what the right direction is, Gilpin says. "In those instances, the case manager has already gone to their supervisor and discussed the issue with their peers but they still don't feel comfortable," she says.

When case managers have explored all the avenues open to them and still feel they aren't doing the right thing because of workplace pressure, they have to ask themselves if theirs is a job they can live with or should they move on.

"It's not an easy issue. You can't look at it as a black-and-white issue. There are a lot of pressures placed on case managers in the decision-making process. But this is something we as case managers need to consider," Owen says.

What are the consequences of unethical behavior? If someone files a complaint against you, your certification can be revoked and the state licensing board notified. You also could be sued.

"The upside of practicing ethically is that, in the long run, case managers are providing better care to individuals. It's a great risk management tool to keep them out of legal problems," Gilpin says. ■

HIPAA privacy regulation sparks varied solutions

Think 'reasonable, good faith'

Hospitals are running the gamut of possible solutions as they struggle to interpret the provisions of the the Health Insurance Portability and Accountability Act (HIPAA) privacy rule, says **Tony Mogavero**, director of physician services for St. Petersburg, FL-based John Putnam International, a company that provides web-based and teacher-led education for access personnel.

His advice is to keep in mind the terminology the *Federal Register* uses — "reasonable safeguard

COMING IN FUTURE MONTHS

- Denial management: The role of the case manager
- How to measure your case management effectiveness
- Emergency department case management
- Dealing with 'frequent flyer' patients

and good-faith effort" — in regard to protecting patient privacy, says Mogavero, who conducts workshops for hospitals and physician groups on the implications of HIPAA.

A hospital in Plant City, FL, is calling by number, rather than name, patients who are waiting for lab work, concerned about the possible privacy violations associated with sign-in sheets, he notes. A physician practice he has worked with uses a vibrating pager, much like those employed by restaurants, to alert patients that it's their time to be seen, Mogavero says.

Other providers have eliminated the sign-in sheet altogether, or destroy it right away, compromising their ability to document patient visits for Medicaid, he adds. On the other end of the spectrum, he says, are those who display a sign-in sheet with not only patient names, but dates of birth and Social Security numbers. In one extreme interpretation of the privacy law, he says, a hospital's employees were taking an allergy sticker off a patient's chart. Proper privacy measures can vary, Mogavero suggests, depending on whether the health care provider is, for example, a primary care clinic with a large number of HIV-positive patients or an ophthalmologist practice. In the latter case, he questions whether substituting pull-off numbered labels for the sign-up sheet routine actually is necessary. ■

CMS offers database for record disclosures

The Centers for Medicare & Medicaid Services (CMS) has created a Privacy Accountability Database to aid in tracking, reporting, and accounting the disclosures made from all CMS systems of records permitted by the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act.

Information retrieved from the system will be used to support regulatory, reimbursement, and policy functions performed within the agency or by a contractor or consultant; support constituent requests made to a congressional representative; and support litigation involving the agency.

The announcement appeared in the Oct. 7 issue of the *Federal Register*. Go to: www.access.gpo.gov/su_docs/fedreg/a021007c.html. ▼

Web site answers FAQs about HIPAA

A "Frequently Asked Questions" document about the Health Insurance Portability and Accountability Act (HIPAA) privacy rule is posted on the Department of Health and Human Services' web site.

The document answers questions ranging from privacy rights to compliance dates. "Does the rule create a government database with all individuals' personal health information?" and "If patients request copies of their medical records, are they required to pay for them?" are examples of the subjects covered. The document also reminds health care providers that the compliance date for the privacy rule is April 14, 2003, or April 14, 2004, for small health plans. To see the questions, go to www.hhs.gov/ocr/faqs1001.doc. ■

CRITICAL PATH NETWORK™

'Hands-on' application tracks nursing care, results

Standardized nomenclatures aid benchmarking

A software application developed by the University of Michigan School of Nursing in Ann Arbor offers the promise of providing a means to collect comparable data for nursing care in the areas of diagnosis, intervention, and outcomes, resulting in far more accurate information both for self-evaluation and benchmarking across health care organizations.

Called HANDS (Hands-on Automated Nursing Data System), the application was developed over the past four years.

Currently, it is available in a CD-ROM version, but its developers hope to have it converted soon to a web-based format.

"The nursing profession had already developed standardized terminology to represent nursing care," explains **Gail Keenan**, PhD, RN, principal investigator for the HANDS project. "The reason we began our project was to enable them to pick up common information about patients across a continuum, within units, and across organizations."

Searching for a common language

Although a common language theoretically was available to all nurses, health care organizations still were measuring different things in different ways, she notes.

There were common terms for diagnosis (NANDA or North American Diagnoses Association, classifications), outcomes (NOC or Nursing Outcomes Classification) and interventions (NIC or Nursing Interventions Classification).

However, "if that term is used differently in different organizations, or if you use some parts of the nomenclature and not others, depending on what the organization wants, that means you're not going to have a standardized way of communicating your data," Keenan explains.

So, for example, two organizations may do the same things, but use different terms to describe them. "Some people may say abdomen, some tummy, and others, the lower quadrant," offers **Marcy Treder**, BSN, RN, HANDS project manager. "We're all speaking about a particular location but capturing it in different terms."

"Take hyperglycemia management, which is an NIC term," Keenan says. "There is a set of terms called 'activities.' So the term hyperglycemia management actually reflects not just monitoring blood glucose, but administering glucose, monitoring ketones in the urine, and so on."

On a larger scale, she says, there are some 470 NIC terms. "A given organization might limit the number of terms they would use to, say, 30," she posits.

"They might not include hyperglycemia management, while other organizations would have access to all the NIC terms to describe their care. If you had only 30, those areas not covered by NIC terms would have to be written up in narrative terms," Keenan adds.

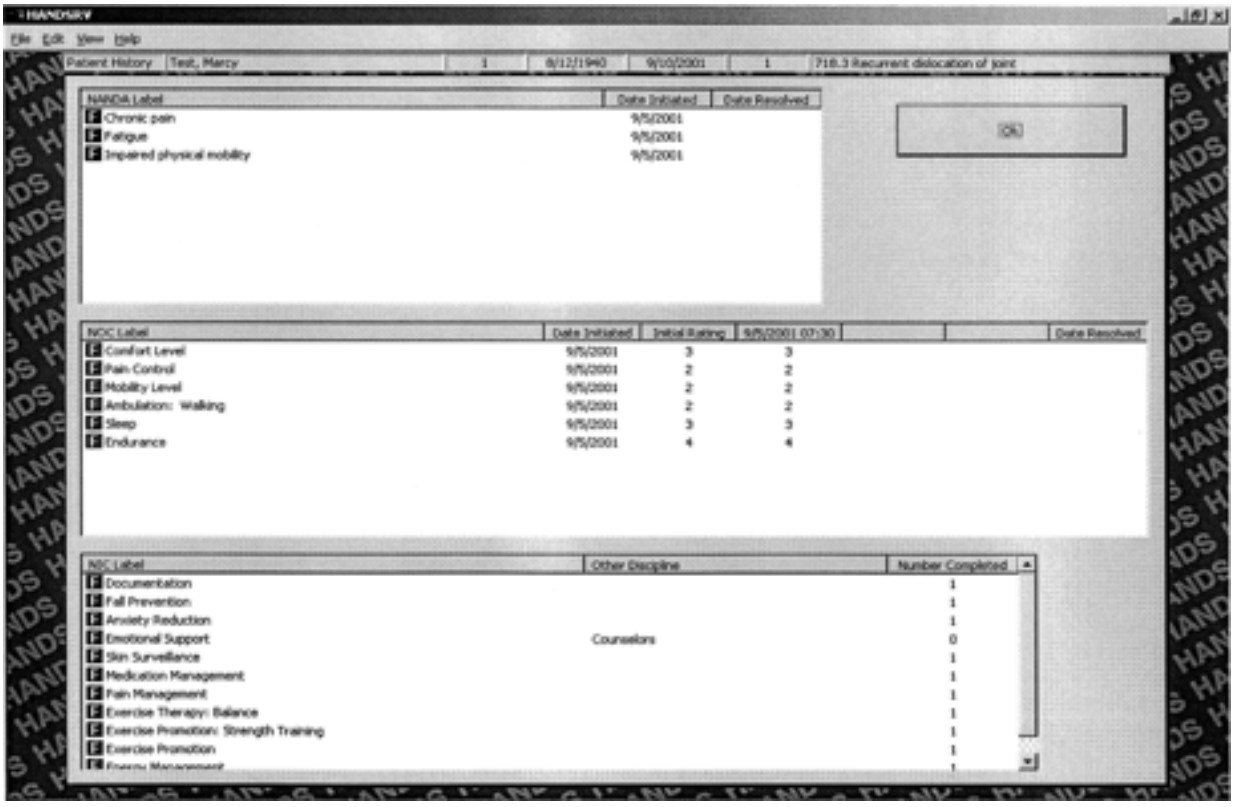
HANDS across the borders

Although care differs across units, they should have access to the same set of terms all the time, the HANDS team argues. That's the impetus for the project.

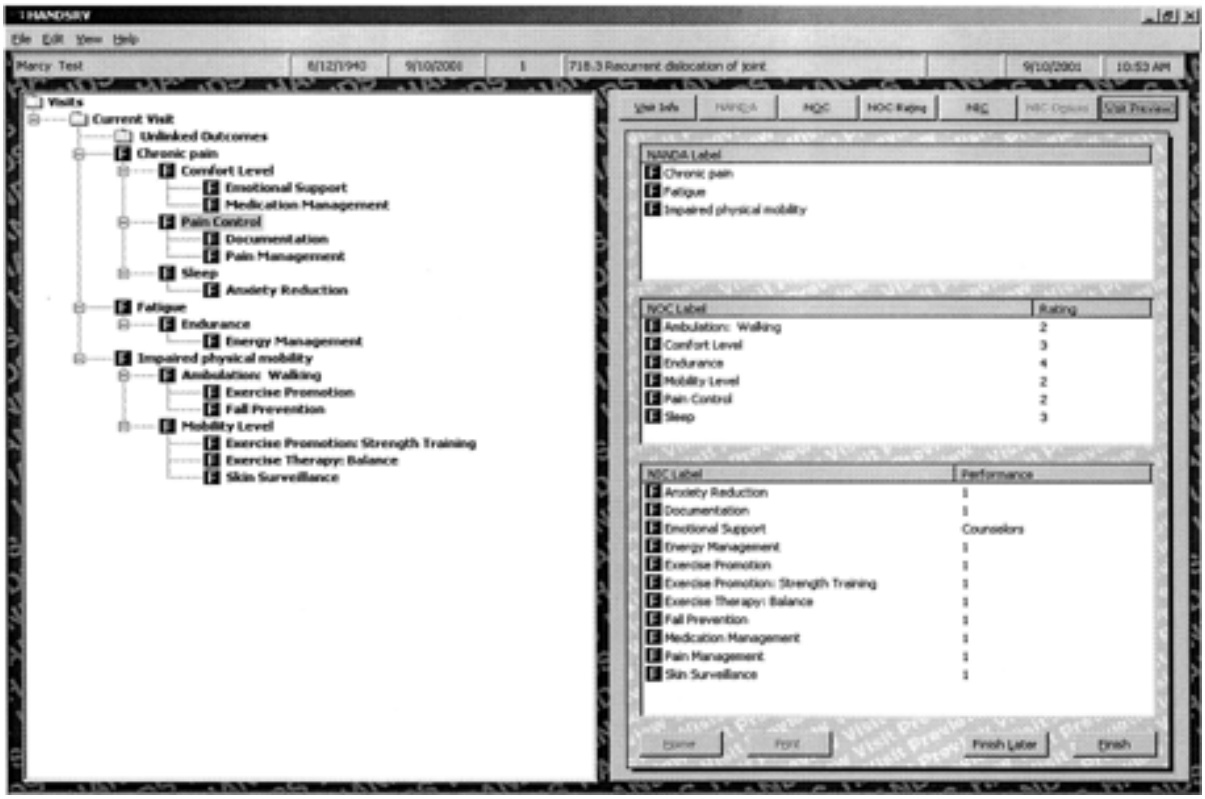
"HANDS is a standard interface through which everyone collects the data in the same

(Continued on page 9)

Episode-of-Care History Screen



Visit Summary Screen



Source for both charts: University of Michigan School of Nursing, Ann Arbor.

way," Treder explains.

"Everybody's got everything, and the search mechanisms to locate what they don't know," Keenan adds. "If you don't know the name of a term, you can search for it. In the glucose example we used earlier, you can search for interventions for high glucose levels or outcomes or problems that are related to glucose."

When using HANDS, nurses merely use a series of pull-down menus to access terms, and enter diagnoses, treatments, and outcomes for each patient. **(See sample screens, p. 8.)** They can not only track current cases but study their progress over time.

"For example, NOC has a measurement scale rating from one to five," Keenan says. "So a nurse is actually giving a rating to the outcome. They can then see if the outcome gets better over time."

The HANDS team predicts its project also can lead to wide-scale benchmarking studies. "We've developed a methodology for the way information is displayed and captured," Keenan explains. "By so doing, the information available across organizations is comparable. There is a whole host of information, and you keep gathering data around the same variables."

HANDS is *not* a recipe for how to operate a unit or a hospital, she adds.

"However, since you use the same methodology, you can capture and compare differences," Keenan notes.

"One culture may be very different from the rest; there may be high staffing levels, good nurse satisfaction, and this may lead to different interventions and perhaps better outcomes. But by comparing the same information, you can benchmark against these other organizations," she says.

The HANDS project has completed Phase I and currently is seeking funding for Phase II (converting the tool to a web-based application and making it operational at several health care facilities). Phase I consisted of setting the nursing outcomes classifications.

"The data set [patient names, diagnoses, interventions, outcomes] — all the variables were entered into HANDS," Keenan says.

"We had nurse researchers shadow the nurses giving care. After talking with the nurses and observing what they did, they would record the information," she adds.

The nurses found the application very useful, Keenan reports. "It provided information nurses usually don't capture; they got a clearer picture of what care was provided to the patient — and they could see everything at a glance."

As for training, nurses are educated to use the language of the three nomenclatures. "Most nurses have not been educated around that, but the software makes it easy," Keenan says.

"We've got the HANDS application up in 17 schools of nursing in Michigan, and those schools are all using it now, so their nurses will know it when they graduate. Those clinicians who do not know it will have to learn it," she adds.

HANDS is a particularly important initiative, Keenan notes, because "What nurses do is not visible to anyone — not even to the nurses."

Most people describe nursing as a caring profession whose members advocate for patients and carry out physicians' orders. "In reality, nurses carry out 80% of the hands-on patient care that is provided," she notes. "What they do has a tremendous impact on outcomes."

[For more information, contact:

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Hospital web sites gain in popularity

The likelihood of a hospital having a web site grew from roughly six in 10 in 2000 to seven in 10 during 2001, according to the Chicago-based American Hospital Association (AHA) Annual Survey of Hospitals.

Survey staffers compiled the numbers by requesting an Internet address in the survey and searching actively for a site at those hospitals that didn't respond to the survey.

Hospitals in New England were most likely to have a web site (83% in 2001), while those in the Mountain states were least likely (54%). Urban hospitals were more likely to have web sites (75%) than rural hospitals (59%).

The complete results are in the 2002-2003 edition of the AHA Guide, which can be found at www.ahaguide.org. ■

IOM to study alternative, complementary medicine

The National Center for Complementary and Alternative Medicine (NCCAM) and 16 Federal cosponsors have unveiled plans for an Institute of Medicine (IOM) study of the scientific and policy implications of the use of complementary and alternative medicine (CAM) by the American public. The $1 million, nearly two-year study will be conducted by the Washington, DC-based IOM, a component of the National Academies.

The National Academies is a private, nonprofit, nongovernmental institution created by a congressional charter to be an advisory body for the nation on scientific and technological matters. The IOM draws upon volunteer panels of experts to examine policy matters regarding the public's health.

NCCAM, the primary sponsor of the study, is the federal government's lead agency for scientific research on CAM. The IOM will assemble a panel of approximately 16 experts from a broad range of CAM and conventional disciplines, such as behavioral medicine, internal medicine, nursing, epidemiology, pharmacology, health care research and administration, and education. During the study, the IOM panel will assess research findings, hold workshops, and invite speakers to address the panel, among other activities, to:

- Provide a comprehensive overview of the use of CAM therapies by the American public.
- Identify significant scientific and policy issues related to CAM research, regulation, integration, training, and certification.
- Develop a conceptual framework to help guide decision making on these issues and questions.

The value of the study came from discussions among members of the Trans-Agency CAM Coordinating Committee, chaired by **Stephen E. Straus,** MD, NCCAM director. "Americans use CAM therapies in record numbers," said Straus, when announcing the study. "The IOM's report will give us a clearer understanding of the scope of CAM use by Americans, as well as CAM's public health impact, and scientific and policy issues that will better inform our research decisions."

The IOM study, led by **Lyla M. Hernandez**, MPH, senior program officer for the Board on Health Promotion and Disease Prevention, will not conduct new surveys of the public regarding CAM use. Rather, the IOM panel will gather and analyze existing data. ■

CE *questions*

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.

1. Which of the following is not one of the four forces that initially created interest in clinical pathways?
   A. changes in economics in health care
   B. length of stay
   C. desire for automation of the health care record
   D. the search for better ways to involve patients, families, and partners

2. List the first of two key steps case managers can take to help people feel confident in the quality of data, according to Patrice Spath, RHIT.
   A. Know the questions that will be asked concerning the data in the information system.
   B. Know the decisions that are to be made concerning the data in the information.
   C. Confirm as much as possible the accuracy and reliability of the data in the information system before preparing reports.
   D. none of the above

3. The 2002 version of the Case Management Society of America's Standards of Practice represents the first revision of the standards since what year?
   A. 1995
   B. 1996
   C. 1997
   D. 1998

4. The Commission for Case Manager Certification in Rolling Meadows, IL, has received large numbers of complaints against case managers concerning ethical violations.
   A. true
   B. false

Answers: 1. B; 2. C; 3. A; 4. B