AMERICAN HEALTH CONSULTANTS®

HOSPITAL CASE MANAGEMENT™

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

IN THIS ISSUE

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SSM's CARE PATHWAYS® boost patient compliance, lower readmission rates

Physician-as-champion approach encourages buy-in

St. Louis-based SSM Health Care (SSMHC), a not-for-profit health system, has instituted a series of case management CARE PATHWAYS that have improved outcomes in several initiatives over the past five years. Results of the programs are shared systemwide to encourage benchmarking and modeling.

Leaders in these efforts see a direct link between case management and quality. "Our basic tenet is they are one and the same; both are directed at what is best for the patient," says **Dan Hoffman**, MD, administrative medical director at St. Mary's Good Samaritan, Inc., in Centralia and Mt. Vernon, IL. "One of the foundations of CARE PATHWAYS is that the best quality of care happens to be the most efficient. If you keep a patient too long in the hospital, complication rates go up. Utilization of services is part of what we look at in terms of quality."

When it comes to quality, the folks at SSMHC know whereof they speak; SSMHC recently became the first health care organization to win the coveted Malcolm Baldrige National Quality Award.

Around this basic foundation, Hoffman explains, SSMHC has identified high-risk areas such as congestive heart failure (CHF), pneumonia, chronic lung disease, myocardial infarction, and strokes. The health system designed CARE PATHWAYS to help streamline the care delivered.

"Doing it the same way is better than doing it the 'right' way," he asserts. "Every physician thinks they are right. If we can get them to do things the same way, it standardizes care and helps in all ancillary services departments. Everyone knows what is expected of them in terms of patient care."

SSMHC's case managers work to ensure compliance with the CARE PATHWAYS, identify outliers and their potential causes, and discuss their findings with attending physicians on a one-to-one basis in what Hoffman calls a "friendly" atmosphere. "We seek to avoid adversarial situations; you

get more flies with honey," he explains. "We're all trying to do what's best for the patient."

This emphasis on teamwork is carried across departments. "Quality and case management are two separate departments," says **Joby Glenn**, RN, BSN, director of case management, "but they work closely together. Case managers will route important issues to quality management for special studies, and answer questions and conduct special studies on what the quality management department does. Then they forward that information to Dr. Hoffman and his committees."

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Editorial Questions

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THOMSON
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"The basic principles for feeding information to other departments applies across the system," adds **Shelley Niemeier**, BSN, MHA, the quality resource center consultant. "Case management directors from every entity in the system meet on a quarterly basis to share issues they have identified. Each medical center also has a quality director, who gets feedback from the case managers. So we have forums across the system where these disciplines work closely and share ideas."

About five years ago, St. Mary's Hospital Medical Center in Madison, WI, began developing CARE PATHWAYS in order to promote a coordinated, patient-centered approach to care delivery. **(For a sample page of a CARE PATHWAY, see p. 19.)** The intent was to optimize the value of care processes through several mechanisms:

- enhanced communication and collaboration among members of the interdisciplinary health care team;
- support and encouragement for the patient and family to become active members of the team;
- promotion of "continuum of care" thinking;
- the streamlining of resource utilization through the adoption of consistent outcomes-based practices.

To facilitate the overall development and implementation processes, a CARE PATHWAYS Advisory Group was formed at St. Mary's. This committee included staff nurses and clinical nurse specialists in pathway leadership roles, representatives from rehab services, utilization review, and health information services.

Over the years, the structure evolved. At the Feb. 5, 1998, meeting, the CARE PATHWAYS Advisory Group formalized its name change to the Integrated Patient Care Council. In addition, the following mission statement was developed: "The purpose of the Integrated Patient Care Council is to increase the value of care and services we deliver. We will accomplish this by facilitating: 1) integration across disciplines and settings within our system, and 2) by development and management of outcomes-based health care practices."

A closer look at one specific pathway — the CHF care path — helps illustrate how the SSMHC system works. The impetus for this particular initiative came from SSMHC's strategic plan.

"It was identified in late 2000 as an opportunity for quality improvement; we had a high readmission rate," explains **Tina Garrison**, CARE PATHWAYS coordinator.

(Continued on page 20)

St. Mary's Good Samaritan, Inc
CHF CARE PATHWAY®

Patient Label

Care Item	ER/ Day of Admission	D	N	Day 1 Date_____	D	N	Day 2 Date_____	D	N
Key Outcomes/Goals	▪ Determine cause of CHF 1. Ischemic (silent) 2. Hypertension 3. Diastolic Dysfunction (LVH) 4. Valvular Heart Disease 5. High Output Failure ▪ Stable emodynamics ▪ Dysrhythmias cont. ▪ Resp. rate <30 ▪ O2 Sat >90%			• Determine cause of CHF • Stable hemodynamics • Dysrhythmias controlled • Resp rate <30 • Neg. Fluid balance • Weight loss (2-4 lbs./day) • O2 Sat >90%□			• Stable hemodynamics • O2 Sat >90% • Neg. Fluid balance • Weight loss (2-4 lbs./day)		
Assessement/ Evaluation	• Nursing Assessment w/lung sounds every 1 hr. & prn (see graphic) • Accurate I&O • Weigh Daily • Continuous oximeter (in ER) • Cardiac Monitor			• Nursing Assessment w/lung sounds every 4 hr. & prn • Accurate I&O • Weigh Daily • Oximeter spot check • Cardiac Monitor			• Nursing Assessment w/lung sounds every 4 hr. • Accurate I&O • Weigh Daily • Oximeter spot check • Cardiac monitor		
Consultation	• As ordered			• As ordered			• Dietary Consults • Cardiac Rehab consult & begin Cardiac Rehab		
Tests	• Echo Doppler • Lab • Xray • EKG • ABG's			• Echocardiogram & Doppler if not completed in ER Check MD order sheet			• Lab • EKG		
Medications/Fluids	• INT--flush every 12 hrs. • DVT Prophylaxis • See MAR • Add meds from orders			• Note changes in medication			• Continue medication administration--see MAR		

Source: St. Mary's Good Samaritan, Centralia and Mt. Vernon, IL.

"In our JOA [Joint Operating Agreement] with Good Samaritan, it was also identified as one of the top areas of financial loss in the hospital," adds Hoffman. "One way to address the problem was through CHF, which was also tied to the readmission rate, as well as to losses in Medicare margin."

The first step involved formulating a team. "We selected a physician champion, one of the cardiologists," notes Hoffman. "If you want to get any new approach accepted, it's very important that you have a non-administrative physician champion to try to get the other docs on board." Then the champion was joined by representatives from all affected disciplines — case management, nursing, physical therapy, respiratory therapy, dietary, home health, social services, and pharmacy.

"We have a core care path team for anything we develop — case management, nursing, and the other core departments. Then we have ad hoc members, depending on the specialty involved," Hoffman explains.

The team met and built an order set containing what the routine orders would be. From that point, they built the interdisciplinary care path that detailed how each of the services would help care for the patient.

The next step was education. Nurses, medical staff, and all ancillary services were given an evidence-based medical rationale for the pathway. Then it was rolled out.

"The case managers then looked at the cases on the floors — how many people were using the pathway, and if not, why not," notes Hoffman. "They presented data on a periodic basis to show what compliance rates were and to give reminders about using the pathway."

Clinical indicators also are assigned to the pathways, notes Glenn. "These are quality issues. Tina [Garrison] gathers information on all patients and compares those who are on and off pathways."

"When we all gather together, we actually do it in a room," adds Garrison. "Everyone has their input right there; it's not just a paper trail."

Patient education is another important piece of the puzzle, Glenn notes. "We give the patients their own pathway — what to expect every day," she explains. "They are told what will happen each succeeding day, how long they should expect to be in the hospital, and so on. It's been very beneficial."

Here, too, teamwork is important. Once the documents are developed, they are brought to the medical staff for their opinions. "The docs will tweak it a bit and personalize it for their own facility," Glenn says.

Clinical collaboratives promote teamwork

Another initiative at St. Louis-based SSM Health Care (SSMHC) that helps improve outcomes and engender physician buy-in is the "Clinical Collaborative" process.

As part of this process, SSMHC's physicians work with other caregivers, administrators, and staff to make rapid improvements in clinical outcomes. Selection of clinical collaboratives occurs in alignment with system goals, such as improving patient outcomes and satisfaction and improving patient safety.

SSMHC has undertaken six collaboratives, involving 85 teams in 2002, up from 14 teams in 1999. The results for SSMHC's clinical collaboratives for patients with congestive heart failure and ischemic heart disease demonstrate levels that approach or exceed national benchmarks.

"The Clinical Collaboratives are developed on a systemwide basis," explains **Dan Hoffman**, MD, administrative medical director at St. Mary's Good Samaritan, Inc., in Centralia and Mt. Vernon, IL. "We conduct research to find specific disease processes or care areas that need to be improved. As the initiative develops, we integrate tools into them like the CARE PATHWAYS, protocols, and standing orders.

Each hospital has a multidisciplinary team that works on the project, which presents another opportunity to get case managers and quality improvement directors involved, Hoffman adds. ■

Benchmarking these pathways is made easy though technology. "All representative hospitals have access to each care path through our Intranet," Hoffman notes. "Why reinvent the wheel? Different facilities will, however, tweak the pathways for their unique environments."

Identifying physician champions is just one way physician support is engendered at SSMHC.

One of the other major strategies involves the educational piece created at the conclusion of the care path development, says Hoffman. "At that time, either a local speaker or an outside speaker — hopefully someone local who is also the physician champion — will present the care path to the audience that will use it."

The process is evidence-based, Hoffman notes. "The approach is: This is the best way to take care of the patient. For example, you need an ACE inhibitor, or this kind of workup, but this other procedure is not necessary, for these reasons."

Only then is the new pathway rolled out. "Those who have bought into it will use it, and then others will use it because doctors are competitive; they will feel that if they're not using it, they are not part of the game," Hoffman explains. "We appeal to their egos and to their competitive natures."

Support for the pathway is then reinforced on an ongoing basis by sharing comparisons between on-path and off-path results in departmental meetings, newsletters, and so on.

Hoffman and his colleagues also have developed clinical teams across both campuses to present the data to those involved in a given specialty of care. "As they see on-path lengths of stay go lower and outcomes improve, care path usage rates go up," he notes. "If you show a decent doc the valid data, he will use it."

Another strategy involves placing emergency department medical directors from each facility on the team. "Considering the number of patients who present there, it's important to get their buy-in," Garrison says.

SSMHC is continuously re-evaluating the existing CARE PATHWAYS, Garrison notes. "Each CARE PATHWAY order set is evaluated at least twice annually by the respective CARE PATHWAY team, and changes are made as necessary," she says. "In other words, when a new order set and CARE PATHWAY are released, they are not set in stone. This is an important component of our commitment to achieving the best possible care for our patients."

A prime example of this continuous pathway evolution is the newest addition to the CHF pathway. "One of the key issues we identified in terms of readmissions is patient compliance upon discharge," notes Hoffman. "We think we've educated them, but when they get home they often forget what they learned. So we have added a full-time nurse who does nothing but make follow-up phone calls."

During these calls, the nurse asks the patients if they are taking their meds, doing their daily weights, and so forth. "We can even get them scales if they can't afford one," says Hoffman.

Trying to keep these patients healthy and prevent unnecessary readmissions is a top priority, he adds, and technology comes in handy here as well. "St. Mary's at Madison uses an electronic scale that is attached to the patient's phone line. The phone also 'speaks' and reminds the patients to weigh themselves, asks them if they took their medicine, if they're following their low-salt diet, and so on," he notes. "The information is downloaded at the hospital. The patients love it, and we hear it has really helped in post-discharge compliance." Because of its success, he notes, the technology will be expanded to other CARE PATHWAY initiatives as well. ■

Hospital achieves 90% compliance with pathways

Facility wins Ernest A. Codman Award

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in Oakbrook Terrace, IL, recently presented the Ernest A. Codman Award, which recognizes excellence in the use of outcomes measurement by health care organizations to achieve improvements in the quality and safety of health care, to Children's Hospital and Health Center in San Diego. Established in 1954, Children's Hospital is the San Diego region's only designated pediatric trauma center and the only area hospital dedicated solely to pediatric care.

Children's was the recipient of the award in the hospital category for the use of evidence-based, multidisciplinary clinical plans that focus on quality and coordination of care to provide optimal care for its young patients. According to JCAHO, more than 60 pathways have been implemented during the past eight years, dramatically improving the coordination and delivery of care for thousands of patients and resulting in an extraordinary 90% rate of adherence to pathway protocols.

Paul Kurtin, vice president of clinical innovations and director of the Centers for Child Health Outcomes, says the initiative has resulted in a major culture change within the hospital, and physicians have benefited from a significant increase in patient volume. The hospital saved $5.2 million as a result of reductions in per-patient asthma treatment costs, reduced respiratory treatment requirements, and other resource efficiencies, he adds.

Kurtin says the proliferation of pathways has much to do with differences in the epidemiology of disease in adults vs. children. In adults, a pathway for coronary heart disease, cancer, or hip replacement typically is applicable to a large percentage of the total patient population. By contrast, pediatric

care often involves a relatively small number of children with a broad range of conditions. "Once you go beyond diseases such as asthma or pneumonia, you find fairly rare conditions," he explains. "In order to cover a large percentage of our patients, we needed to create many pathways."

When the process started, it was up to the physicians to act proactively by ordering the pathway and getting their patients on the pathway. Kurtin and his colleagues went to the department of pediatrics and the department of surgery and asked if the pathway could become the default mechanism of care. Once that change was implemented, children automatically were placed on the pathway unless the attending physicians objected. "Now, if it is 3:00 a.m., we do not rely on the house staff to think about whether there is a pathway connected with asthma or another condition," he reports.

Kurtin says that change in process improved the rate of compliance with pathways from 20% to the low 90s. It probably will be difficult to exceed the current rate of compliance, he adds, because not every child should be on a pathway. "There are outliers, and there are children with more complicated conditions," he explains. "We are very happy staying in the 90% to 93% range, where we have been for the last couple of years."

Kurtin says the rate of compliance with pathways nationwide typically is in the 15% to 25% range. In some instances, it may reach 40% to 50%, he says. "We have probably at least doubled, if not tripled, the national average," he says. "That has a lot to do with our ability to feed back results of how the children are doing on the pathway almost in real time."

Good results encourage physicians

According to Kurtin, physicians became confident over time that good things were happening in terms of patient care. "It was not a leap of faith," he asserts. "If we had found that the pathways were not helping, I am sure that we would be at zero percent."

Kurtin says the process has become almost self-perpetuating. As more pathways are established, more physicians become engaged. "Because we were able to demonstrate — both by clinical outcomes and financial outcomes — that things were better on the pathway, we received tremendous support," he says. "They see by the data that it is working for their patients, and some of our biggest skeptics in the beginning are our biggest champions now."

He says much was accomplished by coordinating care and making sure the physicians, nurses, respiratory therapists, and, if necessary, the dietitian or social worker were all on the same page. "It was coalescing the teamwork around the child as well, and that really impressed a lot of the physicians," he says.

According to Kurtin, Children's uses physician champions for each of the pathways, in addition to relying on multidisciplinary quality improvement teams. He says the organization's first pathway took nine months to complete. Today, he says, it takes only about a month to develop and fully implement a pathway.

Docs line up to request pathway development

Once the organization got through the learning curve and people began to accept pathways, people started to request them, Kurtin says. "We literally had a line forming for physicians who wanted us to develop pathways."

Kurtin says physician champions are absolutely essential. "It is not worth doing if you cannot get a physician champion, in my opinion," he argues. Champions do not have to be a hierarchical leader, such as the chairman of pediatrics or a division chief, but they do have to be fairly senior, well-respected clinicians. Not only must champions help in designing the pathway, but they also must be able to attract the attention of other physicians, he maintains.

The third role physician champions must fulfill is to talk to their peers and encourage them to use the pathways, Kurtin says. Finally, physician champions are expected to keep the rest of the staff abreast of new developments in the clinical research literature. "We try to update the pathways every six months," he reports.

Kurtin says that final task is important because, with 60 different pathways, the hospital would not otherwise be able to stay abreast of 60 different diseases and all the new drugs, diagnostics, and treatments for those diseases. "They are very proactive in making sure everything is state-of-the-art," he says. "Physician champions are absolutely critical."

In short, Kurtin says the pathway process has succeeded because it gets the whole team engaged, and it lets the nurses know what is going on with the patients. "It has really become ingrained over the years within the culture of our organization," he says. ■

CRITICAL PATH NETWORK™

Pathways to success: Standardizing care throughout a diverse health care system

CareMaps allow targeting of improvement efforts

How to establish and maintain a high standard of care, promote consistency across 18 diverse health care facilities, and develop a culture of quality throughout the system was the challenge that confronted the North Shore Long Island Jewish Health System (NS-LIJHS) in Great Neck, NY. But by developing a comprehensive quality management methodology, which included championing CareMaps with variance analysis, **Yosef D. Dlugacz**, PhD, senior vice president quality management, was able to create databases of care practices that convinced clinical and administrative leadership that the use of guidelines would help to meet this challenge.

Over the past decade, the quality management department has developed and implemented more than 170 CareMaps. "These tools help manage and organize the complex care patients receive," says **Karen Nelson**, assistant vice president quality management for NS-LIJHS, who oversees the CareMap program. An episode of illness involves coordinating care from many disciplines, and information needs to be communicated from pre-hospitalization through discharge. This difficult task is efficiently and effectively promoted via the implementation of the CareMap methodology.

"One of the many advantages of being part of a large health care system is that we can use the expertise and resources from all our facilities to develop best practices and benchmarks for a specific disease process," Nelson explained. "We knew it was important to get stakeholder buy-in, for the people involved in the care delivery to have input into the plan of care."

The system took great pains to develop the CareMaps for maximum utility. Multidisciplinary teams researched current literature and used clinical expertise to establish the standard of care. "It is important to remember that a CareMap is not set in stone once it is developed. On the contrary, as information increases and becomes available, the CareMaps have to be revised and kept continuously up to date. The CareMap, which is part of the medical record, is individualized, based on the patient's needs. It has to be a dynamic and ongoing process," asserts Nelson.

"One of the great advantages of CareMaps and of the use of guidelines is that information provided from the guidelines allows us to target specific performance improvement efforts," Nelson explains. "Our variance database enables us to track whether or not key interventions have been met or unmet, as well as being able to track the reason and source of key outcomes." Such information can be cycled back to the provider, the unit, the floor, the service, or the hospital for performance improvement and educational efforts.

Not only do the CareMaps identify interventions and outcomes for a plan of care, but the database that Dlugacz developed for the system is the source of a tremendous amount of information. "The goal is to reduce variation through measurement, to foster efficient resource utilization, to identify opportunities for improvement, as we increase the care provider's knowledge," Dlugacz explains. In addition, communication among caregivers is improved. This is key to improving patient safety, he adds.

(Continued on page 25)

CONGESTIVE HEART FAILURE
CAREMAP® CODE 311-B

DAY 1 DATE: _____/_____/_____

		Interventions	Outcomes
ASSESSMENT	CONSULTS	1. Nutrition ☐	
	TESTS	2. CXR ☐	Patient's abnormal lab values are addressed
		3. EKG ☐	Met: ☐ Unmet: ☐ Initials:
		4. Pulse Oximetry ☐	1. Patient's O2 sat is > 90%
		Metabolic Panel	Met: ☐ Unmet: ☐ Initials:
		Consider Echo if indicated.	
		CBC	
	MONITORS & TEAM PROCESS	Admission History and Assessment ☐	Patient's V/S are within acceptable limits
		V/S q _____	Met: ☐ Unmet: ☐ Initials:
		Intake & output ☐	
	PROBLEMS/ NEEDS	1.	3. 5.
		2.	4. 6.
PLAN	TREATMENTS	5. Daily Weights: _____	
		IV:	
	MEDICATIONS	6. If Ejection Fraction is below 40% use: Digoxin, Diuretics and ACE Inhibitors unless contraindicated	2. Patient's Ejection Fraction is documented in the medical record. Met: ☐ Unmet: ☐ Initials:
		If ACE inhibitors contraindicated consider use of angiotensin receptor blockers.	Pt is Pain Free Met: ☐ Unmet: ☐ Initials:
		Pain management	
	DIET	2gm sodium or as ordered.	
	ACTIVITY	Ambulate unless otherwise ordered. ☐	
	TEACHING	Orient to unit. Review plan of care ☐	Patient/S.O. understands medication use.
		Teach re: disease process, diet, meds, and	Met: ☐ Unmet: ☐ Initials:
		S&S to report. Pain Scale ☐	Patient/S.O. verbalize concerns of illness.
		Fluid Restriction. Daily Weights. ☐	Met: ☐ Unmet: ☐ Initials:
		Patient Friendly Care Map® given. Init. _____	Patient verbalizes understanding of the pain scale
		Smoking Cessation ☐	Met: ☐ Unmet: ☐ Initials:
		Safety precautions ☐	
	DISCHARGE PLANNING	Assess support network. ☐	Patient/S.O verbalize understanding of the Patient Friendly
		Assess discharge planning needs. ☐	Care Map®
			Met: ☐ Unmet: ☐ Initials:
	TEAM SIGNATURES AND TITLE	1.	3. 5.
		2.	4. 6.

3

CM311 (09/02)

Source: North Shore Long Island Jewish Health System, Great Neck, NY.

Staff complete two forms, the CareMap and the variance form, which are scanned by the system's quality management analysts. Data are aggregated to identify trends. For example, if the congestive heart failure (CHF) patients are not receiving ACE inhibitors on the first day, it's important to know why not and where in the hospital this is failing to happen. The database allows care to be analyzed from the system level down to the individual physician. This information helps leadership prioritize improvement efforts and assists the clinicians with comparative data for education. Without being able to assess the care being delivered across the system, the management of patient care would be isolated in individual silos. "That's not ideal," asserts Dlugacz. "Health care delivery is far too complex for us not to learn from one another and share information."

Professional staff are educated about the CareMaps through various forums: inservices, rounds, conferences, and a train-the-trainer program that is approved for continuing education credits. Once the physicians realize that they are not promoting cookie-cutter medicine but instead are communicating information about the current standards of care, they get on board and see the value of collecting and analyzing these important data, Dlugacz and Nelson agree.

Before CareMaps, inappropriate length of stay signaled that there was a problem to be addressed. With the CareMap methodology, NS-LIJHS provides a proactive rather than responsive approach to the delivery of care. Because the information comes in on a continuous basis, the system can manage problems as they occur. This is a great advantage, both for the patient and for the system.

The NS-LIJHS also has developed "patient-friendly" CareMaps that outline, in lay language accessible to patients, what patients can expect from their hospitalization. Allowing patients to be educated and to be partners in their own care is a great advantage, Nelson explains. With the information they have on their CareMaps, they better understand such things as their medication regime, the rationale for the tests they undergo, the importance of diet and nutrition, how to manage their pain, their expected length of stay, and their discharge orders. Patient satisfaction has greatly increased, she says.

By providing information to caregivers about the expected standard of care, and by helping patients understand the management of their disease, CareMaps have aided in the standardization of care throughout the system. Ongoing analysis of variance data allows for immediate feedback to care providers. This methodology has been used to define, measure, and monitor best practices for optimal patient outcomes. When there is a suboptimal outcome, the source can be targeted right away through the database. This is an invaluable tool, according to Dlugacz.

The CareMap methodology has helped the system reduce day-to-day variation in resource and treatment patterns, while at the same time providing a framework for building a highly efficient outcome-focused care delivery system.

[Editor's note: For more information, contact Karen Nelson, RN, assistant vice president, quality management, North Shore-Long Island Jewish Health System, 150 Community Drive, Great Neck, NY 11021. Telephone: (516) 465-8054. Fax: (516) 465-8376. E-mail: knelson@nshs.edu.] ■

Demand for beds expected to increase

Bed management likely will become an even more critical issue for access managers, with demand for hospital beds expected to increase by as much as 46% in the next 25 years.

A study published recently by Solucient, a health care business research group, says the increase of an additional 238,000 beds is expected to result from long-term demographic shifts in the U.S. population, which could drive demand for inpatient acute care through 2027.

The long-term forecasts also show that total acute care admissions are projected to increase by 13 million cases during the same time frame, a 41% jump from the current number of national admissions. The aging of the baby boom generation, increased life expectancy, rising fertility rates, and continued immigration are all likely to contribute to the 25-year growth in inpatient care, according to the study. For more information, visit www.solucient.com. ▼

Final OPPS rule increases spending

The 1,000-page final outpatient prospective payment system rule, which took effect in January, 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 results in 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 classifications amount, enabling hospitals to reach the outlier threshold sooner. Outlier reimbursement will drop from 50% to 45% of costs above the threshold amount, however. ▼

Emergency care crisis indicated by AZ survey

A statewide survey of recent emergency department (ED) visitors sponsored by the Arizona Hospital and Healthcare Association points to an emerging crisis in the availability of and access to emergency treatment in the state.

The public opinion poll of 925 residents shows that 82% said nonemergency use of EDs is a problem, while 95% said many people are using hospital EDs because they have nowhere else to go for treatment.

Some 88% of those who received emergency care in an Arizona hospital in the past year reported being either very or generally satisfied with the treatment they received, regardless of whether they were rural or urban residents, or whether they were Hispanic. Of those who were dissatisfied, long waits were the most-cited reason. Also, rural residents are considerably more likely (61%) than urban dwellers (44%) to see the availability of emergency care as a problem, the study showed. To see the full report, go to www.azhha.org. ▼

HHS issues final report on regulatory reform

The final report of the Department of Health and Human Services Advisory Committee on Regulatory Reform features 255 recommendations to improve care delivery by reducing the regulatory burden on health care providers.

The recommendations address overly burdensome, and at times unnecessary, patient assessment tools; better coordination of the release of new requirements; clarification of rules governing emergency care; and more consistency and reliability from contractors that process Medicare claims and advise hospitals.

They also urge streamlined record-keeping and reporting requirements, such as the Medicare cost report. The committee, created last year, is composed of consumers, physicians, nurses, and other health care professionals. More information is available at www.regreform.hhs.gov. ▼

CMS proposes tracking hospital referrals to HHAs

The Baltimore-based Centers for Medicare & Medicaid Services has issued a proposed rule to require the collection of information on hospital referrals to home health agencies and other entities with which the hospital has a financial interest.

The purpose of the rule is to ensure that patients have an opportunity to make an informed choice of home health agency to which they are referred.

Once collected, the information will be made available to the public.

Hospitals are required to show a list of Medicare-certified agencies that serve the patient's geographic area. They must indicate the agencies with which there is a financial interest, and hospital personnel are not permitted to specify an agency that must provide services.

To read the full text of the proposed rule, "Nondiscrimination in Post-hospital Referral to Home Health Agencies and Other Entities," go to: www.access.gpo.gov/su_docs/aces/aces140.html. Select "title" in the search terms, and enter 11/22/2002 as the search date. ■

Providers customize form for giving notice of rights

Length varies, depending on wording

Notifying patients of their privacy rights under the Health Insurance Portability and Accountability Act (HIPAA) is one of the tasks that fall most squarely onto the shoulders of access management.

The final HIPAA privacy rule allows hospitals to forgo the original written consent requirement for patient information disclosure, but in turn specifies that staff must obtain signatures indicating that patients have received notice of their privacy rights.

Mary Staley, MBA, PT, vice president of HIPAA operations for the Houston-based consulting firm Healthlink Inc., says privacy notices being developed by providers she's familiar with range anywhere from two to 12 pages. "That just depends on how the lawyers have worded it, and that's not to say they won't be revised again to be five pages," she says.

Touro Infirmary has managed to include the necessary information in a one-page front-and-back form, notes **Wade Wootan**, JD, the facility's risk manager, but it's written in 10-point type. "Normal font, normal print, it would be seven to eight pages."

A variety of templates for the privacy notice can simply be found by typing the words "HIPAA privacy notice" into an Internet search engine, adds **Liz Kehrer**, CHAM, system administrator for patient access at Centegra Health System in McHenry, IL.

A quick glance at the web, for example, yielded an eight-page privacy notice for Jackson Health System in Miami. The notice could be read in English, Spanish, or Creole, and contained such headings as "Who Will Follow This Notice," "Our Pledge Regarding Medical Information," "How We May Use and Disclose Medical Information About You," "Special Situations," and "Your Rights Regarding Medical Information About You."

"You can customize [the form], but various components have to be included," Kehrer says. "There are two choices: You can give out the form every time the person registers, or you can have a mechanism to identify when one has been issued."

If any of the information on the form changes between patient visits, another notice would have to be issued and another signature obtained, Kehrer notes. One of the requirements, for example, is that the notice must include the name and telephone number of the person at the hospital who can be contacted if the patient feels his or her rights have been violated, she adds. That means that a staffing change would make the form obsolete.

"[Providers] are only required to give the notice the first time they contact the patient post-April 14, and then when the form is changed," explains Staley. "Most [providers] say they can't monitor that every time, so whenever possible, they'll document receipt of that notice."

Many organizations, she adds, simply are adding the privacy rights notice to the "sign here, sign there" ritual in which patients already participate.

The Ohio State University Medical Center is working to find a way to keep from overwhelming patients with multiple privacy notices, says **Shannon Haager**, assistant director of patient access services. "As a health system that is closely integrated with private physician offices, we are trying to figure out if there's a way to simplify the process so the patient is not getting the notice at the physician's office and the hospital."

In some instances, she notes, a patient might see the physician and then walk next door to a hospital lab. "Are there ways to streamline the process so the patient doesn't receive [a privacy notice] everywhere they walk in the door?"

The question being looked at, Haager says, is

how to "put some flags in the system so we know if the patient has just been given the notice next door. How do we do the customer-friendly thing?"

With most customer handouts, she adds, "we find about 25% [of the material] left behind in the lobby." ■

Mind your EMTALA signage, expert cautions

Don't overlook placement of important signs

A number of hospitals have been cited in the past few months for lack of signs notifying patients of their rights under the Emergency Medical Treatment and Labor Act (EMTALA), according to **Stephen Frew**, JD, a longtime specialist in EMTALA compliance.

All of the facilities cited had signs, although several had remodeled and forgotten to put them back up, says Frew, a web site publisher (www.medlaw.com) and risk management consultant for Physicians Insurance Co. of Wisconsin in Madison.

"The biggest problem was location," he explains. "All of these hospitals got cited for not having all of the proper locations covered, and they all got cited for not having signs in their ambulance entrances, among other locations," he points out.

Access managers with emergency department (ED) responsibility should take note of the following reminders regarding EMTALA signs, he suggests.

Signs, everywhere signs

Signs must be present in entrances that access the ED or obstetrics (OB) areas; in most hospitals, that amounts to all public entrances. As noted, signs particularly need to be posted in the ambulance entrance.

Signs must be in waiting areas where EMTALA patients regularly are seated, including overflow waiting areas. This means that areas such as one-patient waiting areas that are only used by the ED sometimes must still have signs. Other areas include urgent care, walk-in clinics, OB areas, and psychiatric intake areas.

Signs must also be in all treatment areas, which includes all treatment rooms and bays, and signs must be placed in registration areas used by walk-in patients. This includes cubicles used for privacy purposes.

The size of the sign matters. Regulations require that the signs must be clearly visible and readable at 20 feet. This typically means that signs with adequate fonts are in the range of 18 x 20 inches. Signs in small areas where the patient cannot be 20 feet from the sign can be smaller. Typical treatment room and cubicle signs are 8 x 10 inches.

EMTALA regulations indicate that the signs must comply with the Limited English Proficiency standards of the Department of Justice (DOJ) and the Office of Inspector General. Recent revisions to the DOJ standards set the threshold for signs in non-English languages at 1,000 patient contacts or 5%, whichever is lower. These are hospital contacts, not just the contact rate for the ED or a specific department.

Language for the signs, as specified by the Centers for Medicare & Medicaid Services, is available on Frew's web site. ■

Hospital slashes waits with bedside registration

'30 minutes or less' . . . or free theater tickets

Oakwood Hospital and Medical Center in Dearborn, MI, is using the slogan "we're an emergency room, not a waiting room," and is backing up its claim with an offer of free theater tickets to patients who wait more than 30 minutes.

The hospital is part of a trend toward moving the emergency department (ED) registration process to the bedside or the back end of the patient visit, which is helping providers cut wait times while still adhering to Emergency Medical Treatment and Labor Act (EMTALA) regulations, says **Stephen Frew**, JD, a longtime specialist in EMTALA compliance.

Over the course of 84,000 visits, the hospital gave out only 500 sets of tickets to a local theater production, says Frew, a web site publisher (www.medlaw.com) and risk management consultant for Physicians Insurance Co. of Wisconsin in Madison. The guarantee has expanded to all seven hospitals in the group with which Oakwood is affiliated, and the hospital is considering cutting the guarantee to 15 minutes, he adds.

Moving the registration process into the treatment area typically requires "a major change in

attitude among physicians," Frew notes. "[Physicians] either don't want to pitch in and be part of being more aggressive in expediting their work, or they have the idea that they would be seeing more people, which would bring in more non-paying patients."

That outcome would differ from location to location, he says, but in the case of Oakwood, the new process actually brought in more paying patients. "The results were that people were coming from the suburbs, bypassing other hospitals to get cared for there." ■

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 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.

Mogavero conducts workshops for hospitals and physician groups on the implications of the Health Insurance Portability and Accountability Act. His advice is to keep in mind the terminology the *Federal Register* uses — "reasonable safeguard and good-faith effort" — in regard to protecting patient privacy.

A hospital in Plant City, FL, concerned about the possible privacy violations associated with sign-in sheets, is using numbers, rather than names, to summon patients who are waiting for lab work, he notes. One 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, compromising their ability to document patient visits for Medicaid, he adds. On the other end of the spectrum 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, one 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. ■

5. St. Louis-based SSM Health Care was the first health care organization to win what national award?
   A. Ernest A. Codman Award
   B. Malcolm Baldrige National Quality Award
   C. AHIMA Triumph Award
   D. NPSF Patient Safety Award

6. In 2002, St. Louis-based SSM Health Care undertook six clinical collaboratives, involving how many teams?
   A. 14
   B. 34
   C. 85
   D. 102

7. The pathway compliance initiative at Children's Hospital and Health Center in San Diego has helped save how much money from reductions in per-patient asthma treatment costs, reduced respiratory treatment requirements, and other resource efficiencies?
   A. $5.2 million
   B. $4.8 million
   C. $3.4 million
   D. $2.2 million

8. Vicky Mahn-DiNicola, RN, MS, vice president of ACS MIDAS+ in Tucson, AZ, recommends which of the following steps when defining a population?
   A. Identify a database that contains the population of interest
   B. List key strategies known for managing the population
   C. Select a population and list reasons why it is of interest
   D. All of the above

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

Using data management for CM populations

Define the population and establish a baseline

Many case management departments are taking a new approach in terms of how they utilize case managers for outcome evaluation and process metrics. According to **Vicky Mahn-DiNicola**, RN, MS, vice president of ACS MIDAS+ in Tucson, AZ, many case managers now are merging various roles into what are called "outcome managers" or "outcome specialists."

Mahn-DiNicola says many case managers actually are having their titles changed to "outcome specialist" and are being organized around key clinical populations. In that capacity, they frequently are responsible for the information about that population and act as the clinical specialist. She says these case managers not only monitor their clinical populations but also examine the data to more accurately determine what is taking place within that clinical population. In addition, they are more involved in finding "leverage points" in the data, she says.

As an example, Mahn-DiNicola points to one case manager with a behavioral health specialty who reviews financial outcomes, clinical practice patterns, and performance improvement and utilization patterns, and performs physician profiling, as these functions relate to a specific population. Because the case manager knows the physicians and best practice standards surrounding the specialty, she is able to recognize opportunities to improve clinical outcomes or financial performance.

Mahn-DiNicola cites four trends that case management departments should be aware of in this area. First, she says hospital-based case managers increasingly are being organized around a group of patients who have similar clinical conditions, such as orthopedic, cardiac, or pediatric.

Even in the community environment, some case management programs specialize in oncology or another specific disease state. For example, she notes one case manager who is focused on multiple sclerosis patients and performs community clinics, workshops, and swimming therapy for that patient population. "Even though her focus is community-based, she is a clinical specialist in that population," Mahn-DiNicola explains.

Second, Mahn-DiNicola says, case managers more frequently are being asked to demonstrate the value of their roles and their interventions to their sponsoring organizations.

Third, case managers often are responsible for outcomes and process performance data within their organizations. "By virtue of that fact, case managers are becoming natural stewards to the business of metric design, performance improvement, and data mining," she says.

Finally, Mahn-DiNicola says case managers are being forced to become more "data-savvy" and more comfortable with data mining in order to identify opportunities for improvement and facilitate changes in clinical practice and care management processes. "It is a good fit," she says, "but to do that and to do it well, case managers must sharpen their skills."

For example, a length of stay of only a day or two for a group of pneumonia patients might look good on paper, but it actually may reflect the fact that these patients were not sick enough to be in this hospital in the first place. Perhaps they could have been managed in an alternative environment at a reduced cost, she argues.

To remedy this situation, Mahn-DiNicola says it sometimes is necessary for case managers to redirect their energy to helping the emergency department establish some form of risk protocol and then to manage the patients identified as low-risk patients using home health. If a large percentage of these patients are coming from nursing homes, it might make sense to have an advanced-practice nurse start making rounds in the nursing homes.

According to Mahn-DiNicola, different strategies are required for different situations. "You are not going to figure out what to do to better manage a population of patients until you have someone with 'clinical eyes' review the data and the patterns and the trends," she says. "That is where we are seeing case managers more frequently utilized in terms of outcome management."

Mahn-DiNicola says the first step in this process is for auditors to be very clear about the population they are examining. "It is not enough to say, 'I follow stroke patients,'" she explains. Rather, they have to communicate why that population was selected for case management in the first place. She says it could be that it was high volume or high risk or possibly experimental in nature and therefore controversial.

Alternatively, Mahn-DiNicola says it might be an area subject to a regulatory focus by the Joint Commission on Accreditation of Healthcare Organizations or the Centers for Medicare & Medicaid Services (CMS).

Mahn-DiNicola says case managers also must be well-versed in best practice literature relating to the care of a specific population. She says that means, among other things, keeping abreast of national guidelines, standards of care, and medical literature. Then she says they must extract from that literature all of the best practice strategies for managing a patient population. For example, if the population in question is carotid endarterectomy, they must know when it is appropriate to do an angiography vs. a duplex ultrasound.

Mahn-DiNicola says case managers also must implement best practice strategies in their organization, reduce variation, and implement standards. It might be a matter of the timeliness of an intervention, she says. For example, the goal might be to get acute myocardial infarction patients in the emergency room and treated with a thrombolytic or an angioplasty in less than two hours. In that case, important measures will include the timeliness of antibiotics, timeliness of certain assessments, timeliness of certain drugs, and code arrest situations.

"Certainly, all the surgical procedures and complications studies that are being undertaken now by CMS are looking at the antibiotic selection and timeliness of when it stopped," she reports.

Mahn-DiNicola says case managers are natural stewards for these kinds of strategies, as well as for patient education. "There are key ingredients that we have to educate patients and families about," she explains. "Case managers are in a unique position to do that."

Another key factor in defining the population is to understand the data available in the hospital system. That means understanding what data elements are included in administrative claims data for UB-92 data and whether there is a pharmaceutical database or payer database to draw on. "Understanding where these data live and where you can tap into it is important," she says.

According to Mahn-DiNicola, it is very important in defining the population to give ample consideration to whether to use a DRG or an ICD-9 code. Many times when you pull patients by DRG, you get very different patients from when you pull them by ICD-9, she says. "It helps to look at the patients, pull them both ways, and see what you have," she explains. "You might have two very different clinical populations."

Mahn-DiNicola says she generally recommends pulling by ICD-9 code. Then case managers have to think about whether they want to select by primary or by secondary ICD-9 codes. "That makes a difference," she adds. "They need to educate themselves about coding to some degree by spending some time with the coders in their medical records departments." That means sitting down with them for a day and learning how these experts actually read medical records and come up with codes. "It is ultimately part of the billing process," she notes. "Case managers simply need to understand how they can capitalize on that and where the problems are."

Identification of population is crucial

Finally, Mahn-DiNicola says it is necessary to identify patients in the database. She says this is critical in order to follow a population of patients over time because case managers must identify the population the same way consistently to trend it over time or to compare it with other populations.

According to Mahn-DiNicola, if case managers do not pull exactly the same population with the same exact inclusion and exclusion criteria, they will wind up with conflicting data. She says it is very important for case managers to clearly identify the population based on an electronic data source such as an ICD-9 code, a CPT-4 code, some type of DRG, or another identifier and then consider the different ways to segment that population into electronic data that can be defined in a homogenous clinical population.

In some cases, Mahn-DiNicola says, case managers might want to look at Medicare patients independently, sort by payer, or use a particular age range. She says it is a matter of becoming familiar with all the data elements in the database where those patients reside.

Because case managers typically are not trained in informatics, they must put a lot of effort into learning what information exists. "That means they have to knock on a few doors and start asking questions and requesting access to raw data," she says. ■

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