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HOSPITAL CASE MANAGEMENT™

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

INSIDE

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What you can do to optimize your hospital's reimbursement

Case managers can help avoid compliance problems, payment denials

Even if you're doing everything else right in your case management program, if you're not paying attention to how coding is done at your hospital, you're missing the boat on potentially huge cost savings and revenue generation.

"The trend is to assume that when money isn't coming in, it must be because of coding problems," explains **Lynne Northcutt-Greager**, CPC, a consultant with Medical Group Management Association in Englewood, CO. For one thing, coding affects not only reimbursement but also a provider's exposure to fraud and abuse charges. If the hospital starts getting claims denials and has to file appeals, then both clinicians and staff will spend more time on the claims, compounding the cost.

That's where case managers come into the picture, says **Deborah Hale,** CCS, president of Administrative Consulting Services in Shawnee, OK. "Compliance is really all about documentation of medical necessity," she says. While physicians may protest that everything they do is medically necessary, Hale points out that local medical review policies provide clear criteria to establish, for example, when a diagnosis will support medical necessity for a particular diagnostic test. "As they make referrals for those types of services, case managers can make sure there is communication of the diagnosis, or the sign or symptom, that is directly responsible for that test being ordered," she says.

Case managers also should take coding into account when performing data analysis. For example, when looking at profitability, consider that a lack of cost-efficiency could be the result of coding the wrong DRG. "Make sure the data's accurate," Hale says. "If the coding data is inaccurate, then the strategies that you utilize to improve efficiency and effectiveness of care might be directed totally inappropriately."

One of the best ways to identify opportunities for improvement is by effectively analyzing case mix index (CMI) — a deceptively simple statistic calculated by adding DRG relative weights for all discharges and then dividing the result by the number of total discharges.

KEY POINTS

- By paying attention to how coding is performed and documented, case managers can make significant impact on the hospital's bottom line by helping optimize reimbursement and reduce the number of claims denials.
- Coding is a particularly important consideration when you're examining data in terms of your case mix index. If coding data aren't accurate, then the strategies you use to improve efficiency and effectiveness might be directed inappropriately. Worse yet, if your case mix index appears to be too high, federal investigators could target your hospital for an upcoding investigation.
- Pay particular attention to coding issues when designing critical pathways and other performance improvement efforts. Eliminating an apparently unnecessary test may cut costs slightly, but it also may prevent your hospital from validating a high-paying diagnosis.

A common mistake is to look at CMI without taking into account possible variances in the severity of your patient population. For example, if a surgeon at a small hospital takes a one-month sabbatical, his or her absence could create significant changes in how patients are cared for. Those changes could be reflected in the volume of procedures performed, as well as in the length of stay and cost per case of individual patients. "A lot of hospitals work at length of stay and cost per case and just assume that all things stay the same all the time. And they may not," Hale says.

Large facilities can have problems, too, when it comes to analyzing costs. For example: A large hospital begins performing a new procedure in cardiovascular surgery. Initial results look good; length of stay and costs are down. "But if you're not measuring that in light of the case mix index, then you could be inappropriately celebrating," Hale says. "It could be that you've just taken some of your big services out of the mix for a while, so the length of stay is skewed. You've got to look at it in relationship to the services being provided, and the case mix index is one measurement of that."

CMI also can serve as a good barometer of whether or not your hospital is at risk of a health care fraud investigation. That's because the Department of Health and Human Services' Office of the Inspector General (OIG) routinely examines CMI to see whether or not a hospital has been upcoding. **(See related story on the OIG and overpayment rates, p. 99.)**

OIG investigators also look at the percentage of cases assigned to various "high-risk" DRGs that they believe are commonly upcoded. "And if they're in a high range in terms of CMI, that would probably target a hospital for investigation," Hale says. "It doesn't mean that the hospital is upcoding. It may mean that they're just doing a better job of documenting and working with their physicians to support the care they provide. Of course, that would come out in an investigation, but it certainly might put you on the front lines to be looked at."

Indeed, the OIG recently concluded an 18-month investigation of upcoding at hospitals in 12 states. That investigation looked specifically at DRG 482.89, the code for bacterial pneumonia, when it is used instead of the lower-weighted code 486, which is for unspecified pneumonia. The national average for coding 482.89 is 3% of all pneumonia cases. Hospitals that deviated from the average were targeted for investigation, says **Melissa Ferron**, principal of Melissa Ferron Healthcare Consulting in Redondo Beach, CA, which represented one of the targeted hospitals.

CMI accuracy is crucial

"Be afraid if you discover upcoding to game the system for additional reimbursement," Ferron cautions. "The recent OIG investigations are a warning to everyone that staff need to be educated on how important it is to be error-free and to follow official guidelines."

One other negative consequence of having a case mix index that's inappropriately high is that it will falsify your data and cause you to look like you're much more efficient than you really are.

On the other hand, an inappropriately low CMI can make you and your hospital look terrible. For one thing, your mortality rate will appear higher than expected. That's because you assess risk of mortality based on the diagnoses reported. "If they're undershooting [those diagnoses], then they're going to have a high mortality rate, and it's going to look like their length of stay and cost per case are higher than their competitors."

Hale stresses that while coding has always been regarded as a reimbursement problem, it's really a data issue. That means, as a case manager, it's your business, too. "All those codes

Fraud investigations cut Medicare overbilling rate

Improper payments totaled $9.3 billion

A new report from the Department of Health and Human Services shows that the government's dogged pursuit of health care fraud and abuse allegations is having its effect on how hospitals code Medicare claims.

According to the report, the rate of improper Medicare payments to hospitals and other health care providers dropped last year to the lowest error rate since the government initiated comprehensive audits three years ago. In fiscal year 1998, the error rate was estimated at 7.1%, accounting for about $12.6 billion. By contrast, the error rate in 1997 was an estimated 11%, or $20.3 billion. That's a one-year decline of about 38%. In 1996, the numbers were even higher, with an error rate of 14%, or about $23.2 billion in improper payments.

Auditors from the department's Office of the Inspector General (OIG), with the help of medical experts, derived those numbers by reviewing a "comprehensive, statistically valid sample" of 5,540 Medicare fee-for-service claims and supporting medical records representing 600 beneficiaries nationwide. The total value of the claims reviewed was $5.6 million. The claims were reviewed in terms of accuracy and legitimacy.

The improper payments resulted from everything from simple errors to outright fraud and abuse, but the OIG auditors weren't able to quantify the exact proportion of intentional fraud. Even so, they identified two main problem areas: billing for medically unnecessary services and upcoding services to secure a higher reimbursement than was justified by the medical record and supporting documentation. Those two areas alone accounted for about $9.3 billion of the total $12.6 billion in improper payments. Another $2.1 billion came from documentation discrepancies. The highest percentage of improper claims, 39%, or about $4.9 billion, was attributed to hospitals. Next highest were physicians (26%) and home health agencies (13%). ■

drive how many dollars you're going to get," Hale says. "They also draw a picture of your hospital, telling the world what kind of health care you deliver. And if the data's not accurate, it's not going to paint the right picture."

A lack of knowledge about coding issues also can undercut the effectiveness of your clinical pathways, Hale notes. This problem typically arises when case managers initiate a performance improvement strategy by examining what can be eliminated without damaging the quality of patient care. Team members may, for example, question the need to do sputum cultures for certain patients, or whether it's necessary to do three blood cultures or to do arterial blood gases in the emergency department.

It's fine to question expenditures, Hale says. But it's also important to know what impact changing the standard of practice will have on reimbursement. For example, say you stop doing arterial blood gases in the emergency department and rely instead on non-invasive pulse oximetry. That may cut costs, but it also doesn't fulfill Medicare's criteria for validating a respiratory failure diagnosis. If you can't validate the diagnosis, your hospital can't bill for it and reimbursement suffers.

Similarly, if you decide to replace sputum cultures with gram stains for pneumonia patients, you won't be able to prove which kind of bacteria is causing the patient's pneumonia. Consequently, you'll be cutting the hospital out of a possible extra $2,500 in reimbursement for identifying a gram-negative bacterial pneumonia.

"When you're looking at what to include in a clinical path and in a particular set of standing orders for a given sign, symptom, or diagnosis, you need to look not only at the clinical significance of what you're doing but also at the financial significance," Hale says. "And you need to have a knowledgeable coder on your multidisciplinary improvement team."

In fact, sometimes it's possible to optimize reimbursement just by choosing more appropriate terminology. For example:

- dehydration instead of azotemia;
- chronic renal failure instead of chronic renal insufficiency;
- atrial fibrillation instead of cardiac arrhythmia;
- blood loss anemia instead of anemia.

Even if your knowledge of coding doesn't include the finer points of coding terminology, you still can help optimize reimbursement by

identifying that a patient has a secondary diagnosis (defined as an additional condition that affects patient care). Many secondary conditions that can serve to increase reimbursement are frequently overlooked or simply not documented. These include:

- dehydration;
- malnutrition;
- fecal impaction;
- chronic obstructive pulmonary disease;
- stable angina;
- compensated congestive heart failure;
- aortic/mitral valve disease.

"Simply identifying malnutrition in an elderly patient can benefit the patient and the hospital," Hale says. "So often, physicians don't give much attention to the patient's nutritional status." Hale notes that many studies have established that addressing a patient's compromised nutritional status can shorten length of stay and lower the cost of treating the primary diagnosis. This holds true for diabetes as well. **(See related story, p. 103.)**

"The case manager certainly can screen for impaired nutritional status by assessing the findings of the dietary consult," Hale says. "By directing the physician's attention to the patient's nutritional status, they're not only going to have the potential to increase their reimbursement, but they're going to increase their measurement of severity of illness as well."

For more information about how case managers can optimize reimbursement, contact:

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KEY POINTS

- In evaluating the performance of your case management department, go beyond broad measures such as length of stay and costs or charges per case, experts recommend. Evaluate pathways in particular in terms of other factors, such as complications, clinical outcomes, patient satisfaction, and hospital readmissions.
- Remember as well that your idea of a successful case management program may differ from that of a hospital administrator. So, in addition to looking at standard clinical and financial outcomes measures, it's important to consider such things as whether case management has helped the hospital increase market share or identify potential business opportunities.
- Managed care organizations have their own expectations as well. They tend to evaluate programs along disease-specific "product lines." If managed care case managers begin focusing more on your management of one particular disease or market, it may mean they've targeted it as an area of potential overutilization.

Demonstrate effectiveness of your CM program

For proof to administration, go beyond cost, LOS

No matter how effectively your case management department functions, all your efforts will have gone for naught if you can't use data to prove your worth to administrators at your facility and officials at the managed care companies with whom your hospital contracts.

The easiest and most common way to assess performance is to benchmark using comparative billing data. Such data are easily accessible, fairly cheap to acquire, and "they do tend to point you in areas where you may be a high utilizer compared to other facilities," says **Judy Homa-Lowry**, RN, MS, CPHQ, a consultant with Homa-Lowry Healthcare Consulting in Canton, MI.

Even so, not all billing data are created equal. For example, Medicare data are easy to get, but they're only published annually and tend to be older than data from other payer sources. Medicare claims data from last year are only now becoming available. On the other hand, "all-payer" data may be published quarterly, but they're more expensive and may be more difficult to analyze and interpret.

Whatever combination of data sources you draw from to benchmark your case management efforts, one key measure of the success of your program is how well your pathways perform. Although pathways are typically evaluated in terms of broad statistics, such as average length of stay and costs or charges per case, examining them in terms of other, more specific measures can give you a clearer picture of their success, Homa-Lowry says.

"It's important to get down as best you can to specific utilization of services when evaluating pathways," she says. For example, have complications been diminished or poor outcomes improved as a result of the pathway? What about patient satisfaction? Have relationships with other clinicians along the patient's continuum of care become more supportive? In a supportive system, Homa-Lowry notes, long-term care and home care providers cooperate to help decrease length of stay and reduce the rate of readmissions. "We see patients view the transition into alternate care delivery systems as a positive experience, and they're ready for it," she says.

Questions to ask when evaluating the success of your pathways include:

- Are they targeting high-volume, high-risk areas successfully?
- Do they serve as tools for providing additional analysis?

While you might have one standard for evaluating the success of your program, hospital administrators and managed care organizations may have different expectations of you, Homa-Lowry notes. Of course, everyone's interested in costs vs. benefits and how well you measure up in terms of the usual broad parameters, including length of stay, cost, charges, outcomes, and satisfaction. But hospital administrators also may evaluate your success at least partially in terms of how well you've helped the hospital increase or decrease its market share.

Compare yourself to competitors

Administrators want to see whether you're able to identify potential business opportunities, Homa-Lowry says. "If you find that you're doing a good job in an area where [another facility] is not, you might have an opportunity to expand services in that area," she adds.

Another, more subjective measure of your success in the eyes of administration may be whether and to what extent you've influenced the behavior of the physicians you work with.

Managed care organizations, on the other hand, take a more global view of how well your organization utilizes services. "They're looking at how well people are treating various diseases or product lines and how they can influence the number of resources," Homa-Lowry says.

Bear in mind that managed care organizations compile their own comparative data as well. If they identify your hospital as an overutilizer in a given area, they may in fact target your case management department for increased scrutiny. "It may be done in a very subtle way by asking the managed care case managers to examine things more closely and look for additional data," Homa-Lowry says. "I always tell people, if your external case managers begin focusing in more on a particular disease or market, it would be good to take a look at that and evaluate your data to see what they're trying to do."

For more information about evaluating your case management program, contact:

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GUEST COLUMN

How case managers can help reduce medical errors

Keep 'situational awareness' during care episode

By **Patrice Spath**, ART
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Patient safety and error reduction have become national priorities. No physician wants to give the wrong medication to a patient; no unit clerk means to transcribe penicillin as penicillamine. In a perfect world, there would be no errors, patient care activities would be under complete control at all times, and there would be no unplanned, undesirable events or accidents. Unfortunately, mistakes do happen in all health care organizations. The tools used for care coordination are important weapons in the war against medical accidents. Clinical paths, standing order sets, clinical algorithms, and other point-of-care reminders can lessen the risk of human errors. Case managers also can play an important role in patient safety by staying informed about the patient's plan of care and monitoring treatment regimens.

The Institute for Safe Medication Practices (ISMP) evaluates medication error data to determine the factors that contributed to the mistakes.

KEY POINTS

- Although mistakes are inevitable, even in the best-run organizations, the tools used for care coordination — such as clinical pathways, standing order sets, algorithms, and other "point of care" reminders — are among the most important weapons in the fight against medical errors in hospitals.
- For example, establish maximum doses for high-risk drugs, and incorporate these criteria into pathways or standing orders. Preprinted order sets and protocols allow staff to focus their attention on relevant patient care issues, rather than spending time rewriting orders and possibly introducing errors into the system.
- Case managers can be particularly effective in helping other caregivers catch and correct mistakes before the patient is harmed.

The common causes of hospital medication errors were reported in the June 3, 1998, issue of ISMP's *Medication Safety Alert*. These problems, along with ways that point-of-care reminder tools can help reduce or eliminate these problems, are listed below.

• Critical patient information (diagnoses, lab values, allergies, etc.) is often unavailable to pharmacy and nursing staff prior to dispensing or administering drugs for new admissions.

Hospitals must identify more effective ways to obtain and communicate pertinent clinical information and never rely on admissions office staff or unit clerks to supply these data. Standardized patient assessment/intake forms can ensure that all relevant patient information is gathered by clinical staff at the time of the patient's admission.

• Medication errors occur most often during the prescribing and administration stages.

Accessible drug information always must be readily available and close at hand for all staff who prescribe and administer drugs. To improve dissemination of pertinent medication usage information, be sure to incorporate details about drug usage into clinical paths, protocols, standing orders, and other point-of-care reminder tools. Consider developing clinical algorithms if clinicians need help in making treatment decisions.

• Policies for handling medication use conflicts between practitioners are often ineffective or absent.

ISMP receives many reports of lethal errors in which orders were questioned but not changed. Establish maximum doses for high-risk drugs, and incorporate these criteria into pathways or standing orders. If a prescribed dose exceeds the recommended level, practitioners should be empowered to take steps to resolve drug therapy conflicts. The improved teamwork that results from pathway development makes collaboration easier and can eliminate flawed communication among disciplines.

• A frequent cause of serious errors during drug administration is the misuse of infusion pumps and other parenteral device systems.

The settings on PCA pumps often default to a standard concentration, requiring the operator to change the setting if a nonstandard concentration is used.

PCA pump settings should be set by one individual and independently checked by another before administration. Incorporate double-check procedures into pathways and protocols. Require sign-off that procedures are followed.

• Simple mistakes due to distractions are responsible for almost three-quarters of all errors that occur during medication order transcription.

While minimizing distractions can help reduce order transcription errors, preprinted orders are a good way to eliminate the chance of errors. With preprinted order sets and protocols, staff can focus their attention on relevant patient care issues rather than spending time rewriting orders. Good examples of the value of these point-of-care reminders are protocols that caregivers use for chemotherapy, heparin, and Coumadin. These drugs are particularly high-risk for medication errors because of dosing complexity and variation of regimens, according to the patient's clinical presentation.

• Inadequate communication causes many medication errors.

Standardizing communication through the use of preprinted orders can reduce errors. However, preprinted orders must be carefully designed and checked. ISMP was notified of a case where a preprinted order listed the dose of magnesium sulfate as 16g (130 mEq) instead of 16 mEq (2g). The pharmacist assumed it was correct because it was listed on the preprinted orders, and he dispensed the dose. The patient became hypotensive but recovered. Case managers should encourage their institutions to develop adequate control mechanisms for evaluating and using order forms to prevent similar types of errors from occurring.

Medication errors are not the only type of mistake that can be prevented by point-of-care reminder tools. The incidence of patient falls and suicides can be reduced through the use of risk assessment tools and prevention protocols. Preoperative checklists can lessen the chance of wrong-site surgery and unexpected complications. While many of these tools were originally developed to reduce costs and unnecessary variation among caregivers, improvement of patient safety is an important by-product.

During the course of patient care, clinicians are likely to make errors. These slips, mistakes, or unsafe practices are often in response to immediate circumstances involving patient care. Physicians must make decisions about phenomenally complex problems, at times under very difficult circumstances. Often, they are in the impossible position of not knowing the outcomes of different actions, but having to act anyway.

Case managers often are assigned to oversee care for injured, frail, or feeble patients. These patients, particularly those with multiple morbidities, have little capacity to respond to treatment errors. The adverse effect of error on one part of the patient's physiologic state may quickly exacerbate failure of other bodily states. Thus, responses of a frail patient to seemingly harmless slips, mistakes, or unsafe acts may be catastrophic. As an integral member of the health care team, case managers play a vital part in error reduction. They also serve an important safeguard role, helping caregivers catch mistakes and correct them before the patient is harmed.

Case managers can help the other members of the health care team maintain situational awareness, which is a term used to describe caregivers' level of awareness of important patient-related information (e.g., clinical status, care plan, etc.). Patients move very quickly through the episode of care and may experience a rapidly changing course of events. Without an accurate awareness of the current state of affairs, clinicians can make mistakes. The case manager should be on the alert for a loss of situational awareness, which creates a climate for errors. For example, a patient may be having trouble swallowing, but no one has brought this problem to the attention of the physician. Or the resident may have ordered a potentially toxic medication, but nursing staff have yet to discontinue the intravenous drip. Quick intervention by the case manager will help alleviate the risk of patient harm.

Case managers should be involved in the investigation of adverse patient care events, as they are very knowledgeable about hospital operations. As a member of a sentinel event investigation team, the case manager can help the team learn how the mistake was caused. The case manager also can make an important contribution by recommending modifications to systems and processes to prevent another similar mistake from occurring. Case managers also should be involved in proactive accident prevention. It is important to identify and report potential hazards to the quality or risk management department. By documenting unsafe situations, case managers can help set in motion the improvement activities necessary to prevent potential accidents and minimize patient injuries.

Health care professionals too frequently have relied solely on the quality of individual performance to prevent patient accidents. Too often, we have warned someone who made a mistake to "be more careful next time." Despite our best efforts to the contrary, things still go wrong. Health care organizations now are beginning to build error-proof processes and correct the real underlying causes of problems. Point-of-care reminder tools like clinical paths, guidelines, protocols, standing orders, and the like can help eliminate some of the process inadequacies that allow or cause mistakes to happen in the first place. In addition, case managers serve as safeguards to protect against a negative patient outcome even if an error occurs.

By sounding an alarm, case managers can help ensure errors are corrected without an adverse result for the patient. ■

Take common comorbidity into account to save money

Diabetics consume 30% to 40% more resources

A secret cost driver may be inflating your lengths of stay and costs per case.

Studies show that patients with diabetes spend two to three days longer in the hospital than non-diabetic patients with similar complaints, and they consume 30% to 40% more resources. Even so, clinicians often don't bother dealing with the disease if it doesn't seem relevant to the problem that caused the hospitalization.

KEY POINTS

- Flagging patients with diabetes — even when they enter the hospital for an entirely separate illness or injury — can help your hospital save significant resources and cut your average length of stay, according to a panel of diabetes experts.
- The Nashville, TN-based Diabetes Treatment Centers of America says diabetic patients account for 15% of all hospital admissions and 20% of all hospital days and costs. And they consume about a third more resources than other patients who enter the hospital with similar complaints.
- A panel of experts convened by DTCA recommends promptly identifying patients with diabetes; identifying and addressing any special needs they may have; improving outcomes by optimizing glycemic/metabolic control; raising the awareness of the health care team regarding the unique challenges of diabetes care; and striving toward the goal of maintaining a length of stay for these patients equal to that of patients without diabetes.

"It's a reality. When a diabetic patient enters the hospital for any reason, the focus on diabetes is frequently lost in the inpatient setting," says **Robert Stone**, MBA, executive vice president of the Diabetes Treatment Centers of America (DTCA) in Nashville, TN.

DTCA says diabetic patients account for:

- 15% of all hospital admissions;
- 20% of all hospital days;
- 20% of all hospital costs.

"In 95% of the cases, the admission has nothing to do with glycemic control," Stone says. "People with diabetes go to the hospital for the same reason[s] everybody else does."

Meeting 'a huge need'

DTCA, a provider of diabetes education and management services to 69 customer hospitals in 29 states and a contractor with HMOs covering 100,000 diabetic lives, provides something most hospitals don't have: a comprehensive plan for inpatient diabetic management.

"It's a huge need," Stone says. "It's never been done, but we knew when we started this about a year ago that we could help hospital and medical staffs identify issues that contribute to the extra stays and adverse outcomes."

DTCA assembled a panel of primary care physicians, specialists, and other health care professionals representing private practice, health plans, and institutions to develop a set of guidelines for inpatient care. The initial recommendations were reviewed by DTCA's scientific advisory council and a panel of faculty specialists at Vanderbilt University in Nashville.

In November 1998, DTCA convened a consensus conference of nearly 100 health care professionals in Key Largo, FL, to modify and endorse the plans aimed at improving diabetic inpatient outcomes.

"Continued inattention to the unique needs of the inpatient with diabetes is both costly and professionally unacceptable," the panel wrote in a report.

The panel noted that metabolic control of diabetics requires detailed attention to the patient's diet, activity, and medications in the outpatient and inpatient settings, but "too often physician orders or even a hospital's standing orders fail to take into account many aspects of the patients' preadmission status and self-management regimen."

Whatever the condition that caused the admission, Stone points out, "Diabetes is an underlying concern. Our goal is to reduce costs by improving the health status of the diabetic population."

Hospital staff should be able to discharge patients in better glycemic control, he explains, and avoid readmission for infections or other complications.

The panel began with these five recommended goals:

- **Identify all patients with diabetes.**
- **Identify and address any special needs of patients with diabetes.**
- **Improve outcomes by optimizing glycemic/metabolic control.**
- **Raise the awareness level of the health care team with respect to the unique challenges of diabetes and current standards of care.**
- **Strive for a length of stay equal to that of a patient without diabetes.**

The guidelines include a detailed baseline assessment to be performed upon admission by the physician, nurse, or other health care provider. They detail protocols for identification, assessment, and laboratory procedures and name the health care professional who should be responsible for each step along the way and the frequency

(Continued on page 113)

CRITICAL PATH NETWORK™

Improving renal transplant pain management

By **Christiane M. Dines**, MS, RN, CNP
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St. John Hospital and Medical Center
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In April 1996, St. John Hospital and Medical Center in Detroit implemented a renal transplant case management plan (CMP) in an effort to address the quality of patient care while decreasing costs and length of stay (LOS). Six months post-implementation, some positive changes in patient care were realized as a result of tracking variances from established outcomes. For example, there was an increase in patient satisfaction scores describing confidence in the ability to recognize the signs/symptoms of rejection and infection, measure intake/output, and manage dietary restrictions and medication regimens. LOS also decreased from 6.7 days to 6.1 days. Furthermore, the percentage of patients achieving the established educational outcomes increased by 53%.

Despite these accomplishments, LOS exceeded the established target, set at five days. Further data analysis demonstrated consistently high patient self-reported pain scores from day of surgery (DOS) through postoperative Day 3 (POD-3). The established pain level target was <5.0 on a scale of 1 to 10 (1 being little to no pain; 10 being the worst pain the patient has ever experienced). Average highest pain scores reported ranged between 5.2 and 8.2. **(See chart, p. 107.)**

The pain management method routinely used for renal transplant patients was IM Numorphan injections on a prn basis. Further study of this postoperative pain analysis was conducted to determine the average number of Numorphan injections provided in each 24-hour period by POD. In addition, the team recognized that the pain management flowsheets were inconsistently used to assess and record pain scores.

Before an action plan could be developed and put into practice, the renal transplant team realized the need to review published clinical practice guidelines and current protocols. Guidelines reviewed included *Acute Pain Management: Operative or Medical Procedures and Trauma, Clinical Practice Guidelines* (Agency for Health Care Policy and Research, 1992).

It was noted that these guidelines discourage the use of IM injections for pain management due to inconsistent drug absorption. Consultations then were sought with the Department of Pharmacy and the advanced practice nurse for pain management. The team benchmarked with other area transplant institutions, including Henry Ford Health System, Detroit; William Beaumont Hospital, Royal Oak, MI; The University of Michigan Medical Center, Ann Arbor; and the Cleveland (OH) Clinic Foundation, to evaluate practice preferences in relation to pain management for this population.

Results revealed overall support for the use of patient-controlled analgesia with morphine sulfate (PCA-MS). A financial analysis was completed with the assistance of the Financial Department and Department of Pharmacy. Calculated costs (including the drug itself, equipment, and pharmacy/registered nurse labor) were found to be comparable between the two methods. However, the calculated potential cost savings of decreasing LOS by one day for the approximately 50 renal transplant cases seen per year equaled $25,000.

(Continued on page 107)

Renal Transplant Case Management Plan
Outcome Tracking Tool 10/97

Admit date:_____Surgery Date:_____Type of Renal Transplant: (Circle one) LRA, LURT, CRA
Discharge Date:_____

To be completed by the RN by or at Discharge:

Outcome	Yes	No (* explain in variance column)	Variance
1. Patient discharged within 5 days?			
2. Patient demonstrated and/or verbalized understanding of renal transplant post-discharge care?			

Pain Assessment	*Day of Surgery*	*POD-1*	*POD2*	*POD3*
Was the Patient's Pain Score assessed and recorded a minimum of **q4** hours?	Yes No	Yes No	Yes No	Yes No
If Pain Score >5 How long before it was reduced?	Yes<1Hr:_____ Yes>1Hr:_____ Not Reduced:_____ Pain Score Not Recorded:_____	Yes<1Hr:_____ Yes>1Hr:_____ Not Reduced:_____ Pain Score Not Recorded:_____	Yes<1Hr:_____ Yes>1Hr:_____ Not Reduced:_____ Pain Score Not Recorded:_____	Yes<1Hr:_____ Yes>1Hr:_____ Not Reduced:_____ Pain Score Not Recorded:_____
Highest Reported Pain: Score/Time when reported.	Score:_____ Time:_____	Score:_____ Time:_____	Score:_____ Time:_____	Score:_____ Time:_____
Type of Pain Management Method (circle all that apply)	PCA w/MS Oral IM	PCA w/MS Oral IM	PCA w/MS Oral IM	PCA w/MS Oral IM
If on Oral or IM Meds, list name and number of doses in 24 hr period.	Name:_____ Doses Given:_____	Name:_____ Doses Given:_____	Name:_____ Doses Given:_____	Name:_____ Doses Given:_____

Tracking Tool completed by _____

Return to: Chris Dines, APN-Medicine-Nursing Administration
This is a confidential professional/peer review and quality assurance document of the hospital. It is protected frpm disclosure pursuant to the revisions of MCL 333.20175, MCL 333.21515, MCL 331.533, and other state and federal laws. Unauthorized disclosure or duplication is absolutely prohibited.

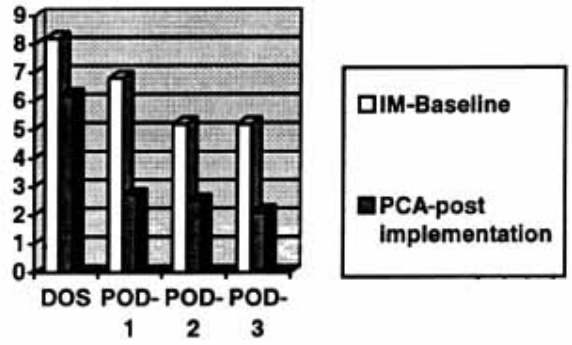
Source: St. John Hospital and Medical Center, Detroit.

A proposal was then developed and presented to the chief transplant surgeon, nephrologists, and other members of the interdisciplinary team. It was decided that the primary method of post-op pain management be changed on the CMP standing orders to reflect "PCA-MS, Pharmacy to Dose" for the first 24 to 48 hours post-op. The patient would then be prescribed an appropriate oral analgesic. Before implementation could occur, the team recognized the need to provide staff of the transplant unit with educational inservices focusing on the latest pain management information, including common misconceptions and documentation policies. The outcome-tracking tool was then revised to assist in evaluating the effectiveness of the change. **(See concurrent tracking tool, p. 106.)** The proposal was implemented as part of the Renal Transplant Case Management Plan in January 1998.

Follow-up data collection has demonstrated success. Average highest patient self-reported pain scores for DOS through POD-3 decreased dramatically. **(See chart, above right.)** Current LOS (4.5 days) is below the established target. Furthermore, patient satisfaction surveys reveal high-level satisfaction with pain relief obtained during hospitalization. In addition, average direct variable costs per case decreased 30% due to a shortened LOS.

The interdisciplinary team recognized that unrelieved pain is the result of many factors, including system issues, prescribing practices, and knowledge deficits. Recognizing that a pain management problem exists and identifying the barriers within the institution is the first step. Once past this obstacle, CQI principles can be applied to the development of an appropriate pain management program.

Average Highest Pain Scores — IM Numorphan prn vs. PCA-MS



Source: St. John Hospital and Medical Center, Detroit.

For more information, contact:
Christiane Dines, MS, RN, CNP, St. John Hospital and Medical Center, 22101 Moross Road, Detroit, MI 48236. Telephone: (313) 343-3072. ■

CMs must develop clear pain policies

JCAHO turns the spotlight on pain assessment

Pain is often called the fifth vital sign, but too often routine pain assessment is overlooked in treatment plans. Lack of routine assessment and adequate education about effective pain management leads to undertreatment of pain symptoms in many patients.

The Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, recently addressed the need for more effective pain management by revising its standards for managing pain in all settings, including the acute, ambulatory, home care, long-term care, health plan, and health system settings.

"Unrelieved pain causes needless suffering and delays healing. Case managers have a vital role in improving pain management. One of the largest barriers to managing pain effectively is that nurses, doctors, and pharmacists receive little formal education in this area," says **Carol P. Curtiss**, RN, MSN, OCN, clinical nurse specialist consultant in Greenfield, MA, and past president of the Oncology Nursing Society in Pittsburgh.

"We make decisions every day as part of our practices," she explains, "but we haven't learned enough about good methods of pain assessment and management."

The first step in a pain management plan is an honest appraisal of the patient's pain, adds **Mark A. Young**, MD, FACP, associate chairman of physical medicine and rehabilitation at New Children's Hospital and the Bennett Institute for Sports Medicine and Rehabilitation and associate co-director of rehabilitation at Maryland Rehabilitation Center, all of Baltimore. "Every patient is different. At the very onset, the physician must establish a clear and accurate picture of the pain."

Young recommends case managers look for the following elements in a thorough pain evaluation:

• a chronological history of the pain;
• activities, treatments, or events that make the pain better;
• activities or events that make the pain worse;
• ability to perform activities of daily living;
• underlying disease processes that cause or contribute to pain or the perception of pain;
• the quality of the pain, such as sharp, dull, radiating or localized;
• therapies tried in the past for pain relief;
• a complete list of medications taken for pain and other conditions.

"There also must be a clear understanding of the psychosocial issues that go along with the patient's pain," he says. "The physician and the case manager must be very directed and targeted and even obsessive at times in obtaining a good pain history. The history guides the future treatment plan and sets the tone and stage for an effective pain management regimen."

Young says these psychosocial issues should be included in a pain evaluation:
• family dynamics;
• work situation;
• emotional cycles;
• history of treatment for depression or other psychiatric disorders.

Show me where it hurts

A pain diary and body mapping diagrams, which chart the areas affected by pain, also are crucial elements of a pain management evaluation and treatment plan, note Curtiss and Young.

"Patients generally come in for initial evaluation and then are typically seen again by the physician a week or two weeks later. A pain diary helps the physician see patterns of pain and pain relief throughout the week and develop a more effective pain management plan," Young says.

Even many cognitively impaired patients can be taught to use a simple pain severity scale, body diagrams, or visual analog scales, say Curtiss and Young. These scales usually use a number range from zero to 10 to rate pain severity, where zero is no pain and 10 is the worst possible pain. Analog scales use faces with expressions ranging from smiling to severely distorted to demonstrate pain severity.

"Once a client is taught how to use a pain severity scale, it's an easy task for the case manager and the treating physician to determine when pain is a problem for the patient," Curtiss says. "Patient self reports of pain and of pain relief go hand-in-hand. If you are only asking your patients to measure their pain, you are only receiving a piece of the picture. You must also evaluate the effectiveness of the interventions that are in place."

Assessing pain by phone

Even case managers who work exclusively or predominantly with patients via telephone can and should effectively assess pain symptoms, Curtiss says. She suggests that case managers ask patients the following questions about their pain symptoms:
• What is the worst your pain has been today?
• What is the best your pain has been today?
• What have you done that made your pain worse?
• What have you done to manage your pain? Has it made a difference? How much relief did it provide on a scale of one to 10?
• What is your pain preventing you from doing?
• What are your goals for pain management? On a scale of zero to 10, what level of pain would let you go about your daily business?

"Asking questions over the phone and assessing the outcomes of your patient's pain management efforts gives the case manager a decent picture of whether the patient's pain symptoms need further investigation," Curtiss says.

She also suggests case managers instruct patients to call them to report the following:
• any experience of new pain;
• any worsening of pain;
• any pain above level five on a zero to 10 rating scale;
• any level of pain unacceptable to the patient;
• lack of bowel movements for two or more days in patients who are using opioids.

"This last bullet gives patients permission to call you for other reasons, including I'm afraid to take this medicine," says Curtiss.

Often the biggest obstacle case managers must overcome in advocating for more effective pain management is the fear common to both physicians and patients that use of certain pain medications may lead to addiction, say Young and Curtiss. "In truth, appropriately used, the risk of addiction with these drugs is less than 1%," says Curtiss.

The important thing is for case managers to explain to patients, families, and, if necessary, physicians, the differences between physical dependence, tolerance, and the drug-seeking behavior associated with addiction, she says. ■

AMBULATORY CARE
QUARTERLY

Cardiac rehab focuses on prevention, home exercise

Regime is customized for each patient

Faced with sending its cardiac patients across town for rehabilitation, a network of providers opened its own cardiac rehabilitation center with services emphasizing prevention and exercises that can be done easily at home.

The Einstein Cardiac Rehab and Fitness Center is a combined effort of MossRehab, Albert Einstein Heart Center, and Germantown Hospital and Community Health Services, all part of the Albert Einstein Healthcare Network in Philadelphia.

The center was opened in summer 1998 to serve patients recovering from heart-valve surgery, angioplasty, heart attacks, coronary artery bypass, heart failure, stable angina, and other heart conditions and procedures.

Instead of a structured exercise program using resistance machines, the Einstein Cardiac Rehab and Fitness Center focuses on preventing future heart problems.

"With shared-risk contracts, everybody has a stake in preventing second heart attacks through long-term management of risk factors such as smoking, diabetes, and cholesterol management," says **Lance Crosby**, RN, MA, director of the Einstein Cardiac Rehab and Fitness Center.

The center's cardiac rehab services include an individualized exercise and education program for each patient. "We try to make it a unique experience for them based on their own rehabilitation and education needs," Crosby says.

Treadmill walking is the primary exercise modality used at the Einstein center because it gives the patients a form of exercise they can do at home without purchasing a machine, he says. "Bikes, rowing machines, and other exercise machines do the job, but humans are primarily a walking machine. I want my patients to be able to leave here and do regular walking as their principal source of exercise."

For the same reason, patients at the center use dumbbells for resistance training rather than machine weights. "My patients can go out for a walk every day and put weights in their bedroom and do exercises with them twice a week. We try to accentuate transference to home activities," he says.

Patients at the Einstein Center go through a one-on-one education program based on nutrition and diet modification, with the objective of getting them down to a diet that includes about 15% of calories from fat.

Patients are asked for a diet history, what foods they normally eat, and whether they eat out or cook at home. Staff help them learn to adapt their current eating methods for a diet. "If they love meatloaf, we help them find a way to change the meatloaf. With the ethnically diverse population we serve, it doesn't make sense to hand out standard diets," Crosby says.

The program is staffed by Crosby, who is a registered nurse and an exercise physiologist, another nurse, and a certified diabetic educator. "Other than nutritional education, diabetic education is the most formalized education our patients receive. Both require a significant amount of discipline," Crosby says.

When a patient is referred to the program, Crosby conducts an initial free evaluation and recommends a treatment plan. He then contacts the patient's insurer to find out if the services will be covered and to what extent. "As a service to the payers, we try to minimize the amount of insurance utilization so we provide value to the insurance company," he says.

For instance, if an insurer agrees for the patient to attend 36 sessions and Crosby feels the patient has accomplished his or her goals in 20 sessions, the center discharges the patient. "We don't try to maximize insurance utilization. There is a price to pay for that in the long run," he says.

Patients generally come to the program for a one-hour session three times a week. Crosby uses

Cardiac rehab adds value to your rehab continuum

Your facility should consider providing cardiac rehabilitation if you refer your cardiac patients to other facilities for rehabilitation, says **Lance Crosby**, RN, MA, director of the Einstein Cardiac Rehab and Fitness Center, part of the Albert Einstein Healthcare Network in Philadelphia.

"A lot of networks see rehab as a value-added service, not a profit center. Reimbursement is good enough so it can be profitable, but it's more a value-added service so you can manage all aspects of cardiac patients within your own network," he says.

If you're thinking of adding cardiac rehab services to your continuum of care, consider these tips from Crosby:

- **Assess whether physicians within your system are demanding this service for their patients.**
- **Determine how many patients your cardiac rehab program might expect.** Crosby estimates about 20% to 30% of patients treated for myocardial infarction or receiving bypass surgery are potential candidates for outpatient cardiac rehab services. Providers can get this information from referring hospitals in their areas, he says.
- **Look at how much space you have available and how many patients you can expect your program to treat before deciding on staffing.**
- **Remember that when a patient participates in an HMO, the primary care physician has to take an initiative on behalf of the patient.** "The doctors have to write a letter recommending your cardiac rehab services for the patient in order for you to get paid. If you've got physician commitment, you can have a successful rehab service," he says.
- **Make sure your key referring physicians have a lot of patients.** You need volume to make your cardiac rehab program succeed.
- **Educate local cardiologists and primary care physicians about the benefits of cardiac rehab.** "If the patient avoids a future episode, everybody wins. The patient wins. The doctor wins. It's good for the rehab facility and good for the payer," Crosby says. ■

the first few sessions to get to know the patients and teach them how to operate the equipment. Spouses often attend the early sessions. The number of sessions varies depending on the patient, with the average being 18.

Crosby is evaluating outcomes measures to decide which ones meet the objectives of his program. ■

Extended therapy hours maximize patient gains

Providing service from 6:30 a.m. to 6:15 p.m.

Faced with having to squeeze a full regime of therapy into fewer days — a practice that often left patients exhausted by midafternoon — Genesys Regional Medical Center in Grand Blanc, MI, has extended its therapy schedule to nearly 12 hours a day.

Now therapy services start at 6:30 a.m. and continue until 6:15 p.m. The change gives patients a chance to rest during the day, makes training and educational sessions more convenient for family members, and relieves the early morning frenzy of trying to get all patients up and dressed in an hour.

When patients are admitted late in the day, they can be evaluated by the therapy staff and fitted for a wheelchair, ready to begin their therapy the next day.

The 32-bed rehabilitation unit has 20 therapists on staff. Before the change in staff hours, occupational therapists worked from 7 a.m. to 3 p.m., and physical therapy shifts were from 8 a.m. to 4 p.m.

Now on weekdays, there are two shifts of occupational therapists: one from 6:30 a.m. to 2:45 p.m. and one from 10 a.m. to 6:15 p.m. Physical therapists work either the 8:30 a.m. to 4:45 p.m. shift or the 10 a.m. to 6:15 p.m. shift.

The hospital's administration chose the 10 a.m. arrival time for the second shift because team conferences start at 10 a.m., and they wanted all staff to be present, says **Daniel Swank**, MPA/CRRN, director of rehabilitation.

As the rehab center's average length of stay dropped from 17 days to a little less than 12, the staff looked at ways to maximize patient gains in the short time they were inpatients, he says. Often, this meant staff were providing far more than the traditional three hours of therapy a day.

"We found that we were cramming all the treatment into five or six hours a day, and the patients did not have time for rest periods. They were exhausted at the end of the day," says **Joy Finkenbiner**, PT, administrative director of physical medicine.

Social workers trying to do group therapy at 3 p.m. complained that the patients were falling asleep. Family members complained the patients were too tired to visit in the evenings.

"If patients weren't in therapy, they were either eating or doing other personal activities. Our new schedule allows them to rest during the day and have time for socialization with their families or go to support groups in the evenings," Swank says.

The change has allowed therapy staff to do family training activities in the late afternoon and be on hand to answer any questions families may have, Finkenbiner says. In the past, families would have to leave work to learn how to care for the patients after discharge, or the therapy staff would volunteer to stay late. "Our family reaching and training program is much more effective now," she says.

The change also has alleviated insurers' complaints about the limited amount of therapy provided to late admissions, Swank says. "Extending the therapy hours to 6:15 p.m. ensures that initial assessments can be completed by the therapists," he says. For example, a recent patient was admitted late Friday afternoon, evaluated by physical therapy and occupational therapy before the shift ended at 6:15 p.m., and started on a full therapy treatment during the weekend. "Insurance companies and physicians really wanted it. It came down to staff availability," Swank says.

Having staff come in earlier in the mornings allows them to help the patients get up and dress themselves, rather than having staff do it for them.

"The whole emphasis of this program is to get patients to be as functional as possible. But when you have to get a lot of patients up and ready at the same time, it's often easier to transfer them or button their clothes for them rather than letting them do it themselves," Finkenbiner says.

Now that some of the occupational therapists are coming in at 6:30 a.m., they can see more patients and provide them with the assistance they need in getting up. Patients who want to get up earlier can do so.

"What it means is that we have a ratio of two to three patients to one staff member for the 6:30 to 8 a.m. time period. It's very manageable and allows the patients to practice their dressing and transferring skills," Swank says.

The dinner hour was changed from 5 p.m. to 6 p.m. This allows patients to rest in the afternoons and have their therapy before dinner.

Genesys started the new therapy hours in early October 1998. The administration gave the staff a month's notice of the new shift changes so the therapists could arrange family schedules. At present, staff members rotate shifts every three months.

The biggest complaints have been from staff who do not want the later shift because they have to find a baby-sitter for their children after school, Swank reports. "We have emphasized that it's not just something management decided to do. It was a problem identified by the patients themselves," he says. ■

Industry group calls for better outcomes measures

Goal: Standardization of reporting

Open any corporation's annual report, and you'll notice one thing: The key message isn't about financial results. It's about the atmosphere in which those results were achieved as well as how the results compare with previous years' performances.

Sales and revenue figures are more meaningful, for example, when they are compared with similar data from competitors, against previous years, and even with the economy and other marketplace factors.

The same could be said for outcomes reporting in the rehab industry. Measuring outcomes is a good start, but actually presenting the data in a meaningful way for managed care organizations and consumers to make health care purchasing decisions can be a major challenge.

One national industry group, the American Congress of Rehabilitation Medicine (ACRM) in Glenview, IL, is reaching out to other industry leaders in an effort to promote what it calls an "evidence-based rehabilitation culture." The goals are greater disclosure of outcomes information and a standardized outcomes measurement tool that will allow a meaningful exchange of data and better benchmarking within the rehab industry.

Health care purchasers can use those data to make purchasing decisions based on quality as well as cost, says **Gerben DeJong**, director of the NRH Research Center at National Rehab Hospital in Washington, DC, and chair of ACRM's research policy and legislation committee.

"We need in the rehab industry to develop a consolidated performance score, a weighted average of several measures," DeJong says. "At some point in the future, it will be important for individual consumers with rehab needs to be able to access [the information] via the Internet."

He says the Functional Independence Measure (FIM), an 18-item assessment tool used by more than 1,300 hospitals nationwide, offers a good starting point. "But it's focused on a fairly limited repertoire of skills. There are a lot of people who think we need to look beyond that. Just because a person acquires these skills, how does it translate to social performance and social role? Nor does the FIM speak adequately to the many other venues where rehab is currently practiced. . . . It's really an inpatient hospital type of instrument."

DeJong's committee is just beginning its work on this effort, he stresses. The group is creating a vision of where it wants to go, and it wants to reach out to other national groups such as CARF ... The Rehabilitation Accreditation Commission, the American Medical Rehab Providers Association, and the American Academy of Physical Medicine and Rehab, among others.

The group hopes to collaborate with other organizations, develop a broad multiyear plan, and perhaps sponsor a national conference. DeJong says the following criteria are crucial to ensure better use of outcomes data:

- a commitment to the value of transparency and the principles of public accountability and disclosure;
- a theory of rehabilitation practice/science;
- a conceptual framework of disability that captures its etiology and consequences;
- a nomenclature and commonly accepted definitions of terms;
- valid, reliable, useful, and agreed-upon measures of function and outcome;
- institution and facility capacities for functional and outcomes data collection;
- large and accessible cross-institutional databases on patient/consumer outcomes;
- full disclosure of standardized risk-adjusted outcomes;
- payment systems that reward quality as well as efficient resource utilization. ■

Translating numbers into useful information

Two hospitals use data to improve performance

Your rehab department has tracked outcomes data for years. In fact, you have two drawers full of quarterly reports to prove it. But have you done anything with the numbers after you've read the reports and filed them away?

Hospital Case Management spoke with two hospital administrators whose facilities are using outcomes data as performance measurement tools to help staff and department managers compare their performances with those of their peers and identify best practices and opportunities for improvement.

At Shepherd Spinal Center in Atlanta, the senior management team issues a monthly report that compares outcomes by teams based on 30 variables, says **Gary Ulicny**, PhD, the hospital's president and CEO.

A performance improvement team, which includes a physician, developed the list. The physician-led teams are categorized by type of patient group, such as paraplegics or acquired brain injuries.

Shepherd created its own executive information system about two years ago that tracks the data, using the Functional Independence Measures as a starting point but adding variables looking at functional activities after discharge from the hospital. For example, what kind of ongoing medical care was needed? How much assistance did the patient need from others to perform daily living activities such as getting dressed?

Data are distributed monthly to physicians, although teams are identified by Physician A, Physician B, and other acronyms. "But everybody knows who's who," Ulicny says. "They became pretty competitive. They see it as an opportunity to learn from colleagues."

Shepherd does not tie performance to compensation, he says, but uses the data in the strategic planning process. "What you see in so many hospitals is they get memos saying they need to submit three performance improvement ideas. Many people will grab on to easy or convenient things. We let the data in our report cards be the guide."

The next step for Shepherd is to dissect a couple of programs to determine what contributes to

an outcome and what doesn't, Ulicny says. One specific component includes a time-study analysis of all nurses in each of the programs. The analysis will determine how each nurse is using his or her time, whether there is work that technicians or assistants can do to free nurses for other duties, and whether other areas for improvement exist.

The hospital has made several improvements based on the outcomes data reported, Ulicny adds. "A couple of years ago, we found that discharge planning had gotten rushed, and [we] were able to retool that significantly," he says.

At National Rehab Hospital in Washington, DC, benchmark data are presented quarterly to administrators and program managers, says **Jackie Ennis**, director of outcomes management. Reports are reviewed by a leadership quality council — which includes the hospital's president, administrator, vice president of nursing, head of clinical services, and head of outpatient services — and by medical directors and department managers.

Data are "cut" by impairment group, Ennis says. Measurements are grouped by these patient types: stroke recovery, orthopedic impairments and disabilities, spinal cord injury, and traumatic brain injury. National Rehab also tracks results within the MEDSTAR health system, the integrated delivery system it belongs to, she says.

"We try to determine how outcomes are affected by participating in other points of the system of care . . . not just by cost but by functional gains," Ennis says. For example, data tracked for a stroke patient might look not only at acute care rehab costs, but also outpatient costs and home health costs, she explains.

Both Ennis and Ulicny say their hospitals have shared outcomes data with payers and have sorted data by payer membership. Payers are particularly interested if you can isolate outcomes to their membership, they say. Their goal is to assign meaning to the numbers.

"Those of us in the field have the tendency to produce lots of numbers, drop the data, and run," Ennis says. "I think it's really important to add value to the outcomes data by focusing on meaning and implication. What does the data mean in context of daily operations or in a strategic context, even if you're simply posing the question with data?"

For example, in one presentation Ennis made to medical residents on staff, she presented data demonstrating that elderly spinal cord patients had shorter lengths of stay than non-elderly spinal cord patients.

"On the surface, this seemed counterintuitive," she says. But during the presentation, medical residents in the audience suggested that many of the non-elderly spinal cord patients were involved in accidents resulting from urban violence, which likely affects the severity of the injury and thus recovery time.

"We went away from the meeting with four requests to look at the data for spinal cord patients in a different way," she says. ■

Reduce medical errors

(Continued from page 104)

with which each step should be carried out.

The panel recommends screening consistent with the American Diabetes Association guidelines for all patients over the age of 18 to detect undiagnosed diabetes.

In the initial assessment for those with confirmed diagnoses of diabetes, the guidelines recommend a physician-performed detailed history, a documentation of symptoms of diabetes-related comorbidities, and a physical exam with emphasis on diabetes-associated findings.

These laboratory tests also are recommended:

- serum creatinine;
- ECG;
- urinalysis;
- blood or serum glucose;
- HbA1c;
- lipid profile.

Health care professionals also are cautioned to look for conditions that may require special considerations in diabetic patients, including the presence of an insulin pump, pregnancy, coronary and cerebral vascular disease, infectious disease, inpatient surgery, and diabetic ketoacidosis.

It's also important to perform a nutritional assessment for each diabetic patient upon admission to devise a specific nutritional plan for the patient, to reassess the nutrition plan frequently, and to devise a discharge nutrition plan with the appropriate instructions and follow-up.

While the patient is in the hospital, the guidelines require optimal metabolic control, with four-times-daily glucose monitoring, daily review, and a goal for fasting blood sugars at 80 to 120 mg/dl and bedtime sugars at 100 to 140 mg/dl. Blood

sugars should not be allowed to exceed 200 mg/dl without intervention, the panel recommended.

The guidelines also call for detailed education, discharge planning, and follow-up by the entire health care team, including demonstrations of the use of blood glucose monitors, self-administration of insulin (if needed), and teaching patients how to check their feet.

"This population is undersupported from an educational point of view," Stone says. "This is an adult learning issue that needs reinforcement, support, and encouragement."

DTCA has printed 15,000 copies of the guidelines and plans to distribute them to hospitals, physicians, state licensing boards, payer networks, and anyone else who requests them.

"They are a work in progress, and we anticipate we will issue updated versions as we get additional input and feedback," Stone says.

Copies of the DTCA Inpatient Management Guidelines for People With Diabetes *can be ordered from: Diabetes Treatment Centers of America, 1 Burton Hills Blvd., Suite 300, Nashville, TN 37215. Attention: Teresa Mabry.*

Robert Stone can be reached at (615) 665-7760. ■

'Grim' prognosis for elderly hospitalized with CHF

Subjects' age makes racial implications unclear

A study by the Centers for Disease Control and Prevention (CDC) in Atlanta paints a dark picture for elderly patients hospitalized for their first time for heart failure. Among patients who survive to be discharged, a third die within a year. And six years after the hospitalization, less than a fifth of the men and a quarter of the women will still be alive.

Lead researcher **Janet B. Croft**, PhD, says it's important to consider this study's data set. Her team looked at 170,239 Medicare patients, all 67 or older. Only patients who were hospitalized for the first time for CHF were included in the study. Because the team studied Medicare claims, there was no way of knowing the patients' functional status or which patients may have been treated for CHF on an outpatient basis.

For this group of patients, white men had a 10% greater risk of mortality than black men. Six years after hospital discharge, the statistics show:

- 19% of black men were still alive, compared to 16% of white men;
- 25% of black women survived, compared to 23% of white women.

The data set selection could explain why black patients seemed to do better than white patients, Croft says. In general, blacks tend to develop CHF at a younger age than whites, she explains. It is possible that by looking only at older CHF patients who were healthy enough to stay out of the hospital until they were older than 67, the black patients could have been in better physical condition than white patients. The typical black CHF patient may have been hospitalized already (and therefore been rendered ineligible for the study) or may have died before reaching the study age.

"There has already been a mortality selection," adds **George A. Mensah**, MD, chief of cardiology and the head of cardiovascular care at the Veterans Affairs Medical Center in Augusta, GA. As patients live to be much older, he says, the racial differences often disappear.

But even though patients lived long enough to be in the study, the chance to survive another six years is not good.

"It may have seemed that black patients did better," Croft adds, "but survival is still bad for everyone."

Croft says greater use of ACE inhibitors and beta-blockers could help keep patients in better control of their heart disease. Using the drugs after patients have a heart attack or develop

hypertension could help prevent heart failure from developing.

"That's the main message we at the CDC are trying to give," she says, adding the agency is now working to educate physicians about using these medications in programs with managed care providers and state peer review organizations associated with the Health Care Financing Administration.

"Almost 50% of heart failure patient hospitalizations could be prevented with the right medication," she says. ■

NEWS BRIEFS

Group raises concern over confidentiality bills

Health information confidentiality legislation is gaining speed on Capitol Hill these days, with three bills introduced in mid-March, but not everyone is gung-ho over the measures.

The Chicago-based American Health Information Management Association (AHIMA) has stated its concern over provisions in the legislation that could endanger health information, not protect it. At issue are parts of the Medical Information Privacy and Security Act, known in the Senate as S 573 and in the House as HR 1057.

"S 573 and HR 1057 contain provisions that would fail to comprehensively pre-empt state health information confidentiality laws, leaving in place the current patchwork of state laws and rules federal intervention is supposed to remedy," explains AHIMA executive vice president and CEO **Linda L. Kloss**, RRA.

Additionally, the bills would treat various types of health information differently and make it impossible to maintain uniformly high standards for management of records, Kloss states.

"All health information is important and deserves equal protection. Treating mental health information, genetic information, and other health information differently would add to the confusion and increase the potential for errors," she says. ▼

Include diverse views in end-of-life policies

Just over half of survey respondents ages 60 to 90 said they would choose to live even if they developed a serious or incurable health condition. The end-of-life decision-making survey of 137 women and 63 men asked what decisions they would make if faced with any of 17 incurable or terminal conditions. Researcher Victor G. Cicirelli, MD, affiliated with Purdue University in West Lafayette, IN, presented the findings at the Gerontological Society of America conference in Philadelphia last November.

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Editorial Questions

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Respondents, consisting largely of blue-collar backgrounds and strong religious beliefs, were given seven choices: trying to maintain life, refusing treatment, withdrawing treatment, letting someone close to them decide, suicide, assisted suicide, or letting the physician decide to end life.

While 51% favored trying to live regardless of the situation, 40% said they wanted others to make end-of-life decisions for them. Only about 10% indicated a willingness to end their lives if little quality of life was the prognosis, noted Cicirelli. Public policy about end-of-life care should allow for differing viewpoints among the elderly, he added. ▼

Joint Commission scales back ORYX requirements

Recently and without much fanfare, the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations (JCAHO) agreed to lower the reporting requirements for its new performance-based accreditation system, ORYX.

When it was first introduced, ORYX required hospitals to submit two measures in 1998 and then add two measures each year until the hospital was reporting on almost all of its clinical care activities. Under the new requirements, a cap has been set at an ultimate total of six measures.

According to officials at the American Hospital Association in Chicago, JCAHO's change of heart came as a result of discussions with state hospital associations, who had felt left out of the process of developing ORYX and who advocated a simpler and less burdensome approach. ▼

Lengths of stay plunge at hospice care facilities

Although the use of hospice care is increasing by 10% every year, the average length of stay for hospice patients is plummeting, according to an unpublished study conducted by researchers at the University of Chicago. The data, reported by the *Chicago Tribune*, show that among patients enrolled at five Chicago hospice networks, about half die within 22 days of enrollment, and about a quarter die within a week. Another report, commissioned by the National Hospice Organization in Arlington, VA, found that lengths of stay at hospices have declined by 14% in the last five years, to a low of 25 days. That's well below the recommended three months in hospice care that many experts recommend for terminal patients. ■

CE objectives

After reading each issue of *Hospital Case Management*, the nurse will be able to do the following:

- identify particular clinical, administrative, or regulatory issues related to the profession of case management;
- describe how those issues affect patients, case managers, hospitals, or the health care industry in general;
- cite practical solutions to problems associated with the issue, based on independent recommendations from clinicians at individual institutions or other authorities. ■