AMERICAN HEALTH CONSULTANTS

HOSPITAL CASE MANAGEMENT™

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

IN THIS ISSUE

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Changing health care environment can make discharge planning a juggling act

Patients have more out-of-pocket expenses, changing benefits

It's no longer enough for case managers to know where patients are going after discharge. Now they have to know each patient's benefits as soon after admission as possible and be aware of what the benefits will and won't cover.

If you are a typical hospital case manager, you probably encounter the following problems more frequently than ever before:

- A patient who is shocked by the out-of-pocket expenses he's going to incur because his health plan no longer covers everything and questions you closely about your discharge plan.
- A patient with no pharmacy benefit who is turned down by a nursing home because of the expense of her post-acute care.
- Someone who is ready to be discharged with home health care but has no home health benefit and can't afford to cover the cost.

Today more than ever, hospital case managers have to do a lot of juggling to see that their patients get the care they need after discharge.

"We thought we were being proactive when we did discharge planning. But now, we're going to have to go more in depth when we do our assessments and focus on the patient's benefits early on," says **Beverly Cunningham**, RN, MS, director of case management at Medical City Dallas Hospital.

Today's workers often have more financial responsibility than in recent years for their health care costs.

In some cases, their employer is moving toward a defined benefit program and expecting the employee to pick up more out-of-pocket expenses. Or they may give people the choice between two insurance plans, an HMO and a PPO, and expect the employee to pick up the extra cost for copay or premium costs if it exceeds a certain amount.

Copay amounts and deductibles are increasing. Medicare and Medicaid no longer cover some of the benefits they covered a few years ago. The

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number of unemployed, uninsured, and underinsured patients is increasing as well.

Even people who have a full-time job with insurance coverage are going to have to pay more out of pocket, adds **Patrice L. Spath**, BA, RHIT, owner of Brown-Spath and Associates, a Forest Grove, OR, firm specializing in educational programs on quality management, utilization control, and patient safety issues.

That means the dynamics between the patient and caregivers are changing as people have to pay more out of pocket for health care.

"Case managers are dealing with people who have no money to pay out-of-pocket expenses and who are looking for community resources. They're also dealing with people who have money to pay out of pocket but will be very questioning about whether the money they are paying will be used appropriately," Spath adds.

The complexity of cases and the number of patients with complex needs are growing all the time, says **Jackie Birmingham**, RN, MS, CMAC, vice president of clinical design for Curaspan, a provider of connectivity and network management across the post-acute continuum.

And it's getting harder for case managers to know what is covered for a particular patient. For instance, Birmingham teaches a class for case managers at a large insurer that writes innumerable variations of coverage.

In today's health care environment, case managers must go back to focusing on discharge planning, Birmingham asserts.

"When hospitals started calling discharge planning case management, a lot of the skill and attention previously given to discharge planning went on the back burner because utilization review takes up so much time," she says.

Now, hospital case managers often have to call the insurance company to get an extra day for the patient or report what is happening with the patient every day. As a result, they have little time for discharge planning, but it's a job that is more necessary than ever if case managers are going to be advocates for their patients.

Case managers are well advised to take a proactive approach and weave discharge-planning needs into utilization management and utilization review.

Case managers should begin a dialogue with a patient's managed care company on admission or prior to admission if it's a planned admission, recommends **Toni Cesta,** PhD, RN, FAAN, director of case management for Saint Vincent's Hospital and Medical Center in New York City. "When you get into a situation when a benefit is not available, it helps to have a working relationship with a managed care case manager," she says. Case managers should begin a dialogue with a patient's managed care company on admission or prior to admission if it's a planned admission, Cesta says.

Most managed care companies have case managers who will work with you on discharge planning to determine what benefit the patient does or does not have.

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Editorial Questions

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After that is established, the two of you should work together toward a safe discharge, Cesta says.

For instance, if a patient is coming in for a hip replacement and is likely to need rehabilitation, the case manager should start working on that benefit before the surgery takes place.

Many managed care companies no longer pay for acute rehab following orthopedic surgery. If this is the case, the case manager should start to plan for a subacute admission or home care.

When you have a question about the interpretation of benefits, call the case manager at the payer and verify whether what the patient needs is covered. If it's not, ask for an individual exception.

The patients most at risk and those who need the most discharge planning are those who are admitted through the emergency department (ED), Birmingham points out.

Most of the time, these are patients who are uninsured and don't go to the physician because they'll have to pay. They know that the hospital ED can't turn them away, so they count on the hospital to give them the care they need.

They wait until they are so sick they end up in the ED. Those at the greatest risk in many cases also are related to the greatest financial risk. Sometimes, they are Medicare patients whose physicians have stopped taking Medicare. They are so sick that the hospital has no choice but to admit them.

If a case manager believes that the patient cannot be discharged safely, the hospital has no choice but to keep the patient.

"It's all in the definition of what is safe. What constitutes a safe discharge is often a nebulous thing," Birmingham says.

Some components of a safe discharge are:

- The patient knows where to get medical care and knows the signs of complications from the illness or injury.
- The patient has a prescription and the supplies he or she needs.
- The patient knows how to take care of him- or herself and has been instructed in things such as wound care and physical activity.

In some cases, post-acute services may not be available for the patient, Cesta notes. "In New York, we can get emergency Medicaid for a patient in the hospital but can't get Medicaid for a patient in the community. We have patients who can be discharged but need continuing care with home health. If there is no free care in the community, the burden shifts back to the hospital," she says.

In many cases, hospitals end up keeping patients longer than they need to stay because they can't safely discharge them.

"For case managers, the discharge planning function means that we are responsible for providing a safe and appropriate discharge plan. When there is a lack of service for continuity of care, we cannot discharge the patient and we won't discharge the patient, so the hospital absorbs the cost," Cesta says. ■

Take a realistic approach when you plan a discharge

Negotiate with MCO or seek community resources

The days are long past when there were few limits to what a hospital case manager could recommend for a patient's discharge plan.

Now, case managers must look at what is appropriate for patients to meet their medical needs and to get them safely to the next level of care, says **Jackie Birmingham**, RN, MS, CMAC, vice president of clinical design for Curaspan, a provider of connectivity and network management across the post-acute continuum.

"I'm not implying that patients' needs have been overplanned for, but often the discharge planner asks the patient about discharge options without regard for whether the patient can afford it," says Birmingham, who has more than 20 years experience in case management and discharge planning. Discharge planning should be a partnership between the case manager and the patient, she adds.

Hospital case managers should spend time with the patients, making sure the discharge plans reflect what they need, what they're willing to do, and what other resources they have, such as family and friends, she adds.

For instance, you may suggest that a patient change his or her dressing twice a day, return to the physician's office at a certain time, and have a home health aide. The patient may agree to everything but then not follow through.

"Case managers need to step back and decide if the patients really need all of this. Patients will usually say 'yes' to almost anything to get out of the hospital," Birmingham adds.

Case managers should assess what is safe for each patient, depending on the home situation,

she adds. For instance, if patients don't have steps in their homes and their hallways and doorways are wide enough to accommodate a wheelchair, they might be able to go home with outpatient rehab instead of being discharged to a rehabilitation facility.

Case managers are required to give patients choices of post-acute care. Instead of offering the patient a "pie-in-the-sky" list of options, assess their needs carefully and offer appropriate choices based on the patient's needs and resources, she advises. "Giving patients choices increases the success, but they should be choices that are good for them," Birmingham adds.

You may have good luck negotiating with a managed care organization for discharge needs that aren't covered if they may prevent a readmission or a complication because it's to the financial advantage of the insurer, points out **Toni Cesta**, PhD, RN, FAAN, director of case management for Saint Vincent's Hospital and Medical Center in New York City. "If you can argue safety and appropriateness of discharge with the third party, many times they will work with you," she says.

Medicare and Medicaid benefits are fairly cut and dried, with little room for negotiation, but sometimes private payers are willing to cover a benefit if it is covered by health plans, Birmingham adds. Since the case manager's job is to ensure that the patient has a safe discharge, the managed care company may be willing to bend a little on certain benefits. For instance, if a patient doesn't have a home health benefit, call the managed care company and ask for a home care evaluation, she says.

One inducement for the managed care company to cover the cost would be that you can't discharge the patient until you know he or she will be safe at home. In other words, if the managed care company won't authorize the visit, the hospital won't discharge the patient.

Following the home health visit, patients know what options they will have.

When case managers look for alternative sources of funding to cover patients' needs, they often must look to resources in the patients' hometown, such as the local agency on aging or a state program for the elderly.

"In the United States, we don't abandon the patient. Even the homeless have rights to some benefit," Birmingham points out. Often, it's a matter of getting the social worker involved. "Some hospitals don't understand the extreme value of social workers in the hospital to help get the patient ready for discharge," she says.

Case managers should involve social workers in the discharge planning so they can work with the family to find solutions to problems, Birmingham suggests.

Know who the social worker is inside and outside the hospital and involve them in finding sources of help for the patient.

Medicare's prospective payment system for home health and nursing homes has complicated discharge planning for patients who need post-acute services, and benefits often are more limited than before.

If these agencies are reaching what they set as their maximum capacity of complex patients, they have the right to refuse to take patients who need complicated and costly care. They want detailed information up front about patients' conditions and needs before they decide to take them.

For this reason, case managers must have a strong clinical description of a patient before they call in the home health agency or the nursing home, Birmingham says.

Sometimes, it takes a lot of juggling to get a patient safely discharged with post-acute care, Cesta adds.

For instance, Medicare doesn't reimburse for medication. If a patient is on an expensive antibiotic, the nursing home may not want to absorb the cost, so it doesn't take the patient.

"In these cases, we will provide the antibiotic because it's more cost effective than keeping them in the hospital. We don't do it very often but we have sent patients to nursing homes with medication," Cesta says. She suggests that when these types of cases occur, case managers do a cross-benefit analysis to see what is better for your facility financially. ■

Educate yourself about alternative treatments

Expect questions as patients pay out of pocket

When physicians write discharge orders for patients, they leave the arrangements for the case managers to make.

This means that the case managers get the questions and complaints about why their post-discharge care is necessary, what is covered, and what the out-of-pocket expenses will be.

Case managers should expect consumers to confront them with questions about their recommendations, physicians' orders, and the cost of health care and should educate themselves so they'll be prepared to answer, says **Patrice L. Spath**, BA, RHIT, owner of Brown-Spath and Associates, a Forest Grove, OR, firm specializing in educational programs on quality management, utilization control, and patient safety issues.

Savvy case managers will educate themselves about what things cost and about alternative types of treatment, she adds.

"Sometimes if a patient asks which is more cost effective, the provider takes affront. Case managers need to know the questions are coming and should be able to answer them," Spath adds.

If the cost of care is coming out of their pocket, patients may choose not to do everything that needs to be done. "One of the problems with the health care system has been that the patient is too far removed from the cost of care. Patients are beginning to be confronted by the cost of care and are going to become more discriminating purchasers," she says. ■

Look to reinsurer for help with catastrophic cases

Additional resources may be available

If you're a hospital case manager with a catastrophically ill or injured patient, part of your job as advocate for the patient should be to find out who may be at risk financially for the patient's care in addition to his or her health insurance coverage, says **Joann C. Milne**, RN, BSN, CRRN, PHN.

"When hospital case managers are handling a catastrophic case, it's important for them to ask if there is a reinsurer involved and if the company has medical management that could help them out," adds Milne, assistant vice president of medical management programs with IOA Re, a reinsurance underwriting company with headquarters in Plymouth Meeting, PA. If a reinsurer is involved, you may be able to find additional resources for your patient's care, she explains.

Milne should know. She was a nurse case manager in a hospital before she took the job with IOA Re. In those days, HMOs had a lot of limitations to rehabilitation and durable medical equipment benefits, often approving only one week of rehabilitation. "Once I found out who the reinsurer was, I would contact that person and let them play devil's advocate with the health plan," Milne says.

By having the backing of the reinsurer and presenting the patient's goals and the expected outcomes if the rehabilitation stay was extended, she often was able to get a longer rehabilitation stay for the patient. Case managers in the hospital setting will be well served by increasing their knowledge of insurance resources and reinsurance resources and understanding what reinsurance does, Milne asserts. "Case managers understand the financial aspects as far as benefits go, but to manage cases, they need to see past that."

Now that many hospitals are taking full risk for some clients, hospital case managers should find out if the patient belongs to the hospital risk pool, and if so, is the hospital reinsured and by whom?

In catastrophic cases, hospital case managers should find out who is at risk for the treatment, whether it's the health plan or the hospital system, and if either party has purchased reinsurance. Start by asking your director of case management who may know if a reinsurer is involved. The chief executive officer, the chief financial officer, and the head of the risk management department should know.

"The important thing is to know to ask the question," Milne adds. Understanding who is financially at risk for care and what resources are available from all at-risk parties helps case managers to be true advocates for their patients and to better coordinate and collaborate, she says.

Developing a good understanding of the insurance component of case management is a way that hospital case managers can distinguish themselves and help their patients at the same time, she adds. If a hospital case manager asks the HMO who the reinsurer is, the health plan is likely to decide to make sure to get the patient's care going in the right direction before the reinsurer gets involved, Milne adds. "You almost shake a tree when you ask the HMO who their reinsurer is and if there is a contact person you can talk to. They are going to have to think twice about what they're doing because, ultimately, the reinsurer will support efforts that assure that appropriate resources are being utilized," she says.

A catastrophic case that involves a lot of coordination of resources, a lot of care planning, and a large allocation of financial resources that may or may not cause the patient to reach his or her maximum lifetime benefit should be a flag to the case manager to find out who is at risk.

"Case managers always should make sure they are doing everything they can to get all the appropriate treatment possible for an individual. The reinsurer may have resources that can help above and beyond what the health plan can do," Milne says. The job of the case manager is to make sure they are doing everything they can to get all the appropriate treatment possible for their patients. The reinsurer is one avenue they can explore for resources beyond what the health plan can do, she adds.

"Part of the case manager's job is to act as an advocate for the patients, making sure they get appropriate treatment, timely coordination of care, and necessary funding to take care of their health care needs. The reinsurer may be a resource to the case manager to help with that advocacy and afford the patient resources above and beyond what the health plan offers," Milne adds. ■

Brush up on economic evaluation skills

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

Case managers frequently are involved in projects intended to identify optimal uses for health care resources. There are clear limits to what types of health care services can be provided, and this means that clinicians have to make choices about diagnostic tests and treatments. Economic evaluations may be a component of a clinical path or guideline implementation project. Often, outcomes management initiatives involve an evaluation of the costs and outcomes (benefits) of the status quo. For this reason, case managers should have a good understanding of how to complete an economic evaluation.

Economic evaluations can take many forms, depending on the perspective of the project and the outcomes under consideration. The most simplistic economic evaluation is one that seeks to determine which treatment is least expensive when two or more treatments are known to produce the same outcomes. The goal of such a project is to *minimize* costs without affecting patient outcomes.

This type of project should be undertaken only when there is reason to believe that the outcomes of each intervention are the same. For instance, if in comparing two forms of asthma treatment there are no differences in clinical outcomes for the defined groups of patients, then it's fine to concentrate on identifying the least costly option. However, if there is no clear indication that the outcomes are the same or similar, by simply concentrating on costs, you could report misleading (and potentially harmful) results.

When a project is undertaken to determine which intervention produces the best outcome for the least cost, it is considered to be a *cost-effectiveness* study. This type of analysis is an appropriate technique to use when the outcomes of different interventions are expected to vary, but these outcomes nevertheless can be expressed in the same terms. For example, a range of treatments are available for the control of hypertension. While the treatment activities can vary, the effects are measured in terms of reductions in diastolic blood pressure (mm Hg).

For a hospital that is concentrating on certain treatment options (e.g., pediatric asthma education), different quantities of the same outcome (e.g., reductions in the number of readmissions for acute asthma attacks) may result. When a common outcome measure is used, the effect of different interventions can be measured in terms of cost per unit of outcome.

A study question such as, "Should a clinical pharmacist be involved in educating patients about their medications?" looks at the *cost-benefit* of a particular intervention. Answering this cost-benefit question requires an understanding of the net benefit of medication education and the costs associated with the educational effort. The steps that should be followed when completing any type of economic evaluation are briefly detailed here.

Posing a well-defined question in an answerable form is the first and most important step in undertaking an economic evaluation. A well-specified question identifies the perspective of the evaluation and the alternatives being compared. These elements have implications for what is to be measured and included in the study. For instance, will the economic evaluation be considered from the patient's viewpoint or the institution's? If the viewpoint of the patient is the focus, then the scope of the study may need to be widened to include costs and benefits that are not of primary interest to the

(Continued on page 63)

CRITICAL PATH NETWORK™

Don't let sepsis threaten patients — watch for signs

Pathway ensures antibiotics are given quickly

When a teen-ager came to Children's Hospital Medical Center in Cincinnati with a sunburn-like rash, a life-threatening cause was identified by an emergency department (ED) nurse.

"He was septic and had meningococcemia, which can kill in just a few hours," reports **Lynn Daum**, RN, BSN, the ED nurse who cared for the patient. A good assessment and rapid treatment made all the difference in the boy's outcome, she says. "We gave megadoses of antibiotics in the ED. He went home a week later, with no unfortunate sequela."

If you were asked to name a leading cause of mortality, sepsis might not come to mind immediately. However, sepsis is the 10th most common cause of death in the United States, and it is increasing due to growing numbers of elderly patients and interventional procedures.[1]

If sepsis is overlooked, adverse outcomes may include loss of fingers, toes, tips of noses and ears, deafness, blindness, renal failure, and even death, Daum warns. Here are effective ways to assess patients for sepsis:

• **Have a high index of suspicion for patient at risk.** The young, the elderly, and anyone who is immunocompromised are at greatest risk for sepsis, and that neonatal sepsis is a leading cause of infant mortality, says **Laura M. Criddle**, MS, RN, CS, CEN, CCRN, CNRN, emergency, trauma, and neurological clinical nurse specialist at Oregon Health and Sciences University in Portland. **(See box, below left.)**

Since sepsis may progress very rapidly to shock, early identification and intervention are essential, says Criddle. She advises doing a quick visual inspection and urine dipstick for any patient with an indwelling urinary catheter, since this is a common source of infection.

Assist with collection of specimens for culture and sensitivity testing, establish good intravenous access, and facilitate the rapid initiation of intravenous antibiotics, Criddle also advises. For patients who arrive in septic shock, airway and ventilatory management, large amounts of fluids, and inotrophes are essential, she says. The early signs of sepsis are subtle and nonspecific, and they frequently are missed in the early phase, she emphasizes. "In general, this is the patient who just looks sick, often with little else that can be pointed to initially."

Assess for subtle increases in respiratory rate and heart rate in the patient at rest, she says. Any level of consciousness changes — such as an infant sucking poorly, failing to make eye contact, and behaving listlessly, or an elderly patient who is agitated, confused, or less responsive than usual — are significant, Criddle adds. Skin signs such as

(Continued on page 58)

High Risk for Sepsis

Sepsis is most likely to develop in patients who:

- have a compromised immune system, often because of treatments such as chemotherapy for cancer or steroids for inflammatory conditions;
- are very young or very old;
- have wounds or injuries such as those from burns, a car crash, or a bullet;
- are addicted to alcohol or drugs;
- are receiving treatments or examinations such as intravenous catheters, wound drainage, or urinary catheters.

Source: International Sepsis Forum, London.

Cincinnati Children's Hospital Medical Center

FEVER of UNCERTAIN SOURCE, 0-60 days
CLINICAL PATHWAY

Page 1 of 2

Path initiated on _____ at _____
Date *Time*

Expected length of stay: 48 hours

Primary Care Physician _____

This pathway is a general guideline and does not represent a professional care standard governing provider's obligations to patients. Care is revised to meet the individual patient needs.

Eligibility Criteria: Infants 0-60 days with a fever >38° C (100.4° F) of uncertain source
Exclusion: Infants with underlying disorders that affect their immunity or that might otherwise increase their risk of serious bacterial or viral infections

Timeline	Presentation at ED	Admission* - 24 hr	24 hr - Discharge
Unit/Dept.	Emergency Department	Inpatient	Inpatient
Date			
Assessment / Monitoring	Vital signs including rectal temperature Symptomatic and exposure history Nursing assessment Post-tap vital signs including BP	Vital signs including rectal temperature every 4 hr BP on admission Review of symptomatic and exposure history Nursing assessment every 4 hr	Vital signs including rectal temperature every 4 hr Nursing assessment every 4 hr
Diagnostics	❑ 0-30 days: septic workup labs, **or** ❑ 31-60 days: bacteremic or septic workup labs as ordered Other diagnostics as ordered		
Medications / IV therapy	Saline well IV fluids as ordered Antibiotics - given within 90 min. ❑ 0-30 days: IV antibiotics, **or** ❑ 31-60 days: IV antibiotics as ordered Antipyretics as needed	Saline well IV fluids as ordered IV antibiotics Antipyretics as needed	Saline well IV antibiotics Antipyretics as needed
Treatments / Procedures			
Nutrition / GI	Ad lib	Ad lib	Ad lib
Activity	Ad lib Child Life	Ad lib Child Life Droplet, Contact or Standard Infection Control Precautions per Infection Control Policy	Ad lib Child Life Contact or Standard Infection Control Precautions per Infection Control Policy
Consults / Referrals		None	Possible ID referral
Psychosocial	Social services or chaplain prn Family charting in medical record as desired	Social services or chaplain prn Family charting in medical record as desired	Social services or chaplain prn Family charting in medical record as desired
Education	Plan of Care Parent Pathway Fever of Uncertain Source - Health Information Topic (HIT/PEP) #1049 Temperature Taking - HIT/PEP #4103 Involve parent at desired level of care.	Review Plan of Care Discharge criteria Well baby care as needed Review of rectal temperature taking Involve parent at desired level of care.	Review Plan of Care Discharge criteria Well baby care as needed
Discharge planning	Discharge criteria reviewed Fever - HIT/PEP #1048 IF TO BE DISCHARGED TO HOME Assure thermometer in home	Evaluate home and family resources. Communication with PCP	Evaluate home and family resources for any treatment continued at home. PCP follow-up arranged.

***Pre-printed orders** HIT = Health Information Topic PEP = Patient Education Program

HIC *Pilot 11/02* *Form #TBA*

Cincinnati Children's Hospital Medical Center

FEVER of UNCERTAIN SOURCE, 0-60 days
CLINICAL PATHWAY
Expected Outcomes

This pathway is a general guideline and does not represent a professional care standard governing provider's obligations to patients. Care is revised to meet the individual patient needs.

		Initials		Initials	
Signatures					
Timeline	**Presentation at ED**		**Admission - 24 hr**		**24 hr - Discharge**
Unit/Dept.	**Emergency Department**		**Inpatient**		**Inpatient**
Date/Time		D E N		D E N	D E N
Physiologic	• Taking PO • Decreased temperature from presentation • Easily consoled		• Taking PO • Decreased temperature from presentation • Easily consoled		• Taking PO • Normal temperature • Easily consoled
Psychosocial/ Comfort	Family verbalizing feelings as calm and reassured.		• Family verbalizing feelings as calm and reassured. • Family resting.		Family participating in discharge planning.
Educational	Family verbalizing understanding of septic workup and Plan of Care. IF TO BE DISCHARGED TO HOME: Family demonstrates competence at taking rectal temperature.		• Family verbalizing understanding of septic workup and Plan of Care. • Family participates in temperature taking.		• Family demonstrates competence at taking rectal temperature. • Family able to continue treatment at home, if necessary.
Other	Family included in care to their desired level of involvement.		• Family included in care to their desired level of involvement. • Parent involved in morning rounds as desired.		• PCP agrees with Discharge Plan. • If indicated, home care arrangements finalized. • Follow-up appointment has been scheduled.
Outcome not met due to:					

For each met outcome, initial = met *** = not met (see progress notes)**

(Continued from page 55)

flushing, pallor, mottling, and even petechiae and purpura are indicators of an advanced condition, she says.

Very young infants are at risk because they have immature immune systems and an inability to thermoregulate, Daum explains. When young infants get cold, they have a tendency to slow down their breathing or even have apnea spells that can lead to life-threatening bradycardia. "We worry about a cold baby as well as a febrile one." Use an infant warmer, she adds. "When we strip infants to do our procedures, we are exposing them to a cool environment."

"We have to help them regulate their body temperature." Many times a fever is associated with sepsis, but fever is not the only indicator, she cautions. "If the whole picture isn't clear, sepsis can be missed. A neonate may be hypothermic instead of hyperthermic and be septic." The child may have a high-pitched cry and be very irritable, Daum says. When doing an assessment, you may notice a sunken anterior fontanel, or a bulging one.

Here are other clues she advises you to look for:
— a history of increased sleepiness;
— decreased intake by mouth;
— decreased urine output;
— sudden onset of fever, rash, or lethargy;
— a pinpoint, nonblanching rash below the nipple line;
— any change in mental status;
— purpuric rash anywhere on the body.

• **Support the cardiovascular system.** Septic patients often need fluid boluses followed by vasopressors to maintain blood pressure, Daum says. If the cardiovascular system is not supported, the patient can very quickly go into shock, she warns. "This can be a life-threatening event."

• **Don't delay in giving antibiotics.** Pediatric advanced life support teaches that in a code situation, the drug of choice is "epinephrine, epinephrine, epinephrine," Daum notes. "For sepsis, it should be antibiotics, antibiotics, antibiotics."

Ideally, antibiotics should be administered within 30 minutes of patient arrival, Criddle says.

Daum's ED's septic workup is given to any infant younger than 60 days old presenting with a fever or history of a fever. It includes a urinalysis, blood culture, complete blood count, serum glucose, and cerebrospinal fluid. **(See clinical pathway, pp. 56-57.)** The pathway ensures that antibiotics are given quickly, she says. "Most of the time we will leave a saline well in the child, as we anticipate giving antibiotics and we don't want to stick the child any more than we have to."

[For more information about sepsis, contact:

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Reference

1. Hoyert DL, Arias E, Smith BL, et al. *National Vital Statistics Reports,* Vol. 49, No. 8. Hyattsville, MD: National Center for Health Statistics; 2001. ■

CE *questions*

13. Which of the following is not a component of a safe discharge?
    A. The patient has a prescription and the supplies he or she needs.
    B. The patient knows how to take care of him- or herself and has been instructed in things such as wound care and physical activity.
    C. The patient does not know the signs of complications from the illness or injury but knows where to get medical care.
    D. all of the above

14. According to Patrice Spath, RHIT, "consumable costs" may include land, buildings, and major items of equipment.
    A. true
    B. false

15. Sepsis is most likely to develop in patients who:
    A. are very old or very young
    B. are addicted to alcohol or drugs
    C. have wounds or injuries such as those from burns, a car crash, or a bullet
    D. all of the above

16. In 2001, Jaris Hammond, ACSW, LCSW, social services coordinator for Hancock Memorial Hospital and Health Services, oversaw the distribution of free medications worth how much?
    A. about $109,000
    B. slightly more than $18,000
    C. $165,000
    D. about $200,000

Answer Key: 13. C 14. B 15. D 16. A

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Hospital's award-winning plan for prescription drugs

Some $150,000 in free meds provided each year

A social work professional at a 100-bed hospital in Indiana is getting free medications for patients who can't afford them with a program she says could be a model for health care organizations across the country.

Using an Internet program called IndiCare (www.indicare.com), which provides access to pharmaceutical companies that offer free drugs to needy patients, **Jaris Hammond,** ACSW, LCSW, social services coordinator for Hancock Memorial Hospital and Health Services in Greenfield, IN, oversaw the distribution of at least $148,500 in free medications in 2002.

She estimates the figure would be closer to $200,000 if she were able to track patients who refill their own prescriptions using cards issued by some of the drug companies.

In 2001, the program received the Eleanor Clark Award for Most Innovative Program from the Philadelphia-based Society for Social Work Leadership in Health Care.

"It can be duplicated without much effort," says Hammond. "That's exactly why it won the award. If everybody in the country could do this, there would be no need for Medicare to pick up the cost of prescription medication."

Before the IndiCare program began, Hancock was spending about $10,000 a year to purchase medications for some 50 needy patients through its medical assistance program (MAP), she explains. Under that program, the hospital and more than 40 physicians from a variety of specialties write off the medical care they provide to patients who meet the guidelines of the federal food stamp program.

"We decided three years ago that maybe it was time to try something else" to address the need for funding for prescription drugs, Hammond says.

A Hancock pharmacist who had heard about IndiCare requested a demonstration of the program, and the hospital eventually paid $3,000 a year to tap into it, she adds. "[The pharmacist] did a trial with three or four patients and then, when she left after three or four months, the program fell into my lap." In the last few months of 2000, when the program started, about $18,000 worth of drugs were distributed, she says. For 2001, the figure was about $109,000.

IndiCare is one of seven financial assistance programs she oversees, Hammond notes. She also serves as the sole social worker for the emergency department, outpatients, obstetrics, and same-day surgery. She also handles the referrals for drug and alcohol programs, as well as for domestic violence, adult protective services and child abuse cases. "I'm the 'go-to' person for our transition [discharge] planners."

That means, Hammond explains, that she would be unable to run the IndiCare program without "two wonderful volunteers." She soon will have a third, she adds. "We also have social work interns and a two-day-a-week secretary who is awesome."

"What we do is go on-line, access what medications are being offered by specific pharmaceutical companies, get the forms, and fill out what's required for their format," she says. "It could be last year's tax statement or, in the case of one who went into [extreme] detail, the patient's electric bills."

Patients don't qualify for the coverage if they are eligible for any other prescription drug coverage, including federal, state, or private insurance, Hammond notes. Most of the drug companies offer nongeneric medication through the program, she says. "If there's a generic [substitute] for it, they won't give it to you for free."

Patients with asthma or chronic lung disease or who need blood-pressure medication for hypertension "are great candidates for IndiCare," Hammond says.

After her office completes the IndiCare application for a patient, she explains, there is "a paper shuffle back and forth with the physicians' lounge" to obtain authorization for the drugs. "[Physicians] sign off on the application, put it in our box, and we mail it in. Most of the medications are delivered to the physicians' offices."

Her office tracks each case, making sure the medicine gets to the right people, and then reapplies, setting the process in motion again, adds Hammond. "The pharmaceutical companies usually send a three-months' supply, so after two months, we reapply."

"Many people have been on the program for three years," she says, "and a lot of them don't have any insurance at all. Sometimes, their medicine costs $1,000 a month."

Frequently, patients can afford to pay their physician but don't have the money for their medications, Hammond notes. "In many cases, [getting the free drugs] prevents them from being hospitalized." This is particularly true for diabetics, many of whom the program helps to obtain free insulin from one pharmaceutical company and free test strips from another, she adds. "Sometimes, I have someone come to my door from the Medicare office and say, 'I've applied for Medicare, but I've been off my meds for two weeks.'"

In addition to the IndiCare program, patients can get help from a private fund called HELPS that is used to buy medications "in a pinch," Hammond says. That fund comes into play "if somebody's in the emergency department [ED], for example, who needs antibiotics for a bad infection or for wound care."

Despite its relatively small size, Hancock Memorial Hospital and Health Services provides a wide range of services, she notes, including hospice care, cardiac catheterizations, a geriatric psychiatric unit, and a rehabilitation unit.

Part of her job, Hammond explains, is helping some of the patients who make use of those services through the seven financial assistance programs she oversees. In addition to IndiCare and MAP, she says, those programs include:

- **Senior Health Insurance Information Program (SHIIP)**, a volunteer program that keeps patients updated on changes in long-term care insurance and Medicare and Medicaid regulations, and provides counseling for those who need it.
- **Women Helping Women,** which Hammond calls "an awesome answer to women who need mammograms and can't afford them. We have a fund-raising dinner once a year and made close to $20,000 with this year's dinner." She adds that the program, which gets a great deal of physician support, "could be modeled by anybody."
- **Breast and Cervical Cancer Program,** a state-funded initiative for which Hammond provides the social work component. "We hired a two-day-a-week person to coordinate that program."
- **Financial Write-off Applications.** "Our little office does at least 200 applications a year for people who don't qualify for MAP, but really can't afford to pay their bill," Hammond explains. This would include someone who "just came to the ED and had a $300 to $400 bill. We take a snapshot of their financial situation and ask for last year's tax return and [documentation of] the last three months of income. On the basis of that information, we write off all or part of the bill. Physicians tend to write off what we write off."

[Editor's note: Jaris Hammond can be reached at (317) 468-4532 or by e-mail at jhammond@hmhhs.org.] ■

Redirect indigent funds for prescription drugs

Hospital spends $1 to provide $16 in medication

W.A. Foote Memorial Hospital in Jackson, MI, has dramatically increased the bang for its prescription drug buck by forming a medication assistance program (MAP) in conjunction with several community agencies, says **Beth A. Smith**, RN, MSN, MBA, director of case management.

Rechanneling funds it originally contributed to a United Way-sponsored operation run by Catholic Social Services (CSS), the hospital developed an in-house program that is providing some $16 in free medications to the needy for every dollar spent, adds Smith, who serves as liaison between the new program and the community.

Previously, she explains, the hospital had contributed $60,000 annually to the CSS program, which also received $50,000 a year from United Way. "They could service about 100 patients a month and would normally run out of money by the middle of the month."

Under that system, the agency gave vouchers

to patients after a cursory financial screening, and the patients went to a pharmacy to purchase their medications, Smith notes. "They paid retail price, so [the program] couldn't service that many people."

Another problem was that there was no case management of the program, which was run by a clerical employee, she says. "One person needed treatment for a toe fungus, and the physician prescribed medicine that costs $200. There are other, less expensive treatments."

Because the CSS program focused on serving as many people as possible, patients received funding for their medications intermittently, maybe once or twice a year, Smith notes. That meant there was no provision for those who were on, for example, long-term heart medication.

Meanwhile, officials at the hospital, which is part of Foote Health System, had been batting around the idea of starting its own indigent prescription drug program, she says. "The issue was funding."

An organization called the Emergency Needs Coalition, which looks at shelter, heating and health care needs in the community, asked a group of agencies to get together and address the prescription drug issue, Smith adds.

After some discussion and initial resistance from those administering the CSS program, the coalition agreed to let Foote take the $60,000 it was contributing to the United Way and use it to fund its own program, she says. "The community felt we could serve more people."

With its own pharmacists overseeing the program as part of their jobs, the hospital uses the funds to pay an annual $4,500 licensing fee for the computer software program Indicare and to hire two pharmacy technicians (1.4 full-time equivalents), who do the processing that the IndiCare computer program requires, she notes.

Approximately $12,000 a year goes to pay for medications that cannot be obtained from pharmaceutical indigent programs or from samples contributed by the drug companies and by physician offices, she says. Those medications are dispensed at cost in the case of brand-name products, or for a $5 copay for generics, Smith adds.

While CSS was able to provide 100 patients a month with about 222 prescriptions, the Foote program provides about 450 patients with a total of 2,300 prescriptions, she adds.

Other results are not as easily measured but are very real, Smith notes. "All of the community agencies have noticed a decrease in the requests for medications, a lessening of the burden." In addition, she says, the hospital has been able to discharge patients earlier because of the availability of home intravenous infusions provided through the program.

"We have received numerous letters from the patients and their families in appreciation of this program," Smith wrote in an application proposing MAP for a national award. "In many cases, it helped relieve what had become a desperate financial situation."

There are plans for expansion, she notes. "We are looking at adding one or two FTEs. The bang for the buck is so incredible. Our pharmacists do this along with their normal job, so we're hoping to add [funding for some] pharmacist hours."

In addition, Smith says, the Emergency Needs Coalition is asking for funds from United Way to replicate parts of the program at the Center for Family Health, a federally qualified health center that serves Medicaid patients and the uninsured.

[Editor's note: Beth Smith can be reached at (517) 789-5926 or by e-mail at beth.smith@wafoote.org.] ■

Partnership gets drugs for needy patients

Discharges are more efficient, staff less frustrated

Obtaining prescription drugs for patients who can't afford them has been a problem for Athens (GA) Regional Medical Center for the 18 years that **Beverly A. Baker**, CRC, CCM, has been with the hospital, she says.

"With the rising cost of medication, this problem had only gotten worse," adds Baker, who is director of social work services. "My staff were spending hours each week looking and begging for medications for patients. The physicians had even gotten to the point where they would refuse to discharge a patient until medications were obtained."

"We were looking at how many discharges were being delayed while we looked for resources," she says. "With hospitals going into bed [availability] crunches, turning over rooms was an issue."

The situation changed dramatically for the better about a year and a half ago, she explains, when the hospital established a medication assistance program (MAP) that works in conjunction with local charitable agencies.

When a patient is being discharged and needs help paying for prescriptions the physician has written, the hospital picks up the cost for the first 30 days, Baker explains, and then refers the patient to a community agency with which the hospital has partnered. That agency assists the patient in applying for the Pharmaceutical Companies Indigent Drug Assistance Program, she adds. "We also do this on readmissions when different medications are required."

Because of the possibility for abuse, the hospital does not pay for pain medications, Baker says, but she notes that for cancer patients, there are other community resources that will cover those drugs. Patients qualify for MAP if their income is below 100% of the federal poverty guidelines and they have no other Medicaid or insurance benefit, she adds.

Once the hospital does its part, Baker says, the community agencies do the paperwork required to obtain the assistance from the pharmaceutical companies. Several agencies participate, including Catholic Social Services, a couple of free clinics, and a fund sponsored by the local newspaper, she explains.

Most patients who need prescription drug assistance, however, are referred to an association of area churches called "ARK," Baker explains, because the group has a program specifically for that purpose.

"If there are language barriers, we refer them to Catholic Social Services," she notes, "and if the person isn't going to meet the income guidelines of the pharmaceutical companies, we look for other agencies." Continued assistance from the hospital is not available if the patient does not follow up with the indigent drug assistance programs, Baker adds.

Although her department still is in the process of developing ways to measure the program's effectiveness, she says, indications are that lengths of stay and readmissions are being reduced. "[Before], we were seeing instances of patients coming in, being discharged, and coming back in because they were not taking their medications. The reason they weren't taking them is because they weren't buying them."

Meanwhile, her staff members are "feeling much more productive," Baker notes. "They spend their time doing more productive things than calling agencies trying to get money to cover the drugs."

[Editor's note: Beverly Baker can be reached at (706) 475-3436 or by e-mail at bbaker@armc.org.] ■

Conference targets quality in case management

Experts will share their proven ideas for successful case management at the 8th Annual Hospital Case Management Conference, **Delivering on the Promise of Case Management: Making an Impact in a Challenging Health Care Environment**, to be held April 27-29, 2003, in Atlanta.

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Direct/Indirect Costs Included in Hypothetical Asthma Education Project

Cost	Group Education Sessions	Education Booklet Distribution
Provider Costs		
Staff	• Cost of nurse educator • Cost of administrative staff	• Cost of administrative staff
Consumables	• Cost of producing education booklets • Cost of sending letters • Cost of appointment phone calls to organize education sessions • Cost of peak-flow meter	• Cost of producing education booklets • Cost of sending letters and booklets
Overheads	• Overhead of meeting room (heating, lighting)	
Patient/Parent Costs		
Direct out-of-pocket expenses	• Cost of buying asthma medication	• Cost of buying asthma medication
Travel expenses	• Cost of transportation to attend education sessions	

Source: Patrice Spath, RHIT, Brown-Spath & Associates, Forest Grove, OR.

(Continued from page 54)

institution, e.g., out-of-pocket expenses or quality of life. An example of a question that focuses on the patient's perspective: "Is a hospital-sponsored self-help support group for the treatment of obesity more cost-effective than the status quo from the patient's point of view?"

In addition to defining the study perspective, the alternatives to be evaluated must be identified. Economic evaluations involve a comparison with at least one alternative intervention to allow for an understanding of how the alternative might have changed the situation. Wherever possible, interventions should be compared with the next best option or options. For example, clinical pharmacists can compare their medication education practices with similar educational interventions by other professionals. Alternatively, patient care practices may be assessed against other (yet similar) interventions taking place in another department or division in the organization.

After specifying the study question, the next step is to create a clear description of the activities associated with the project and its comparator(s). For instance, in the example of pediatric asthma education, the two activities to be compared might be "active" group education sessions for patients / parents and "passive" interventions involving distribution of asthma information booklets to patients / parents. Next, the direct and indirect costs of each intervention are calculated. Direct costs for each of the interventions fall into four main categories: staffing, consumables, overheads, and capital. Staff costs are the costs for any labor involved in the intervention, e.g., direct salary and benefits. Consumable costs are those associated with the items consumed by the intervention, e.g., drugs, diagnostic items, or educational materials. Consumable costs might include any printing, postage, or telephone calls associated with the intervention in question. Overhead costs sometimes are referred to as indirect costs, e.g., heating, lighting, laundry, security, and cleaning services. Capital costs may include land, buildings, and major items of equipment.

Costs for other related services also should be considered. For instance, if community services (such as meals-on-wheels) are used for home-care, the cost of these services also should be included. If volunteers are being used (e.g., to mail out education booklets), their involvement

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also may be costed, even if services are provided for free. There also may be direct treatment/prevention costs for patients and their families. For example, parents may have out-of pocket expenses for attending group education sessions or buying associated products. There may be child day-care costs or costs associated with caring for sick relatives. **(For examples of the costs that may be associated with the two different pediatric asthma education interventions, see box, p. 63.)**

Once all the relevant costs have been identified, it's time to measure them. This usually involves calculating resource use in terms of physical quantities, such as the amount of time spent by educators in group sessions, the number of education booklets produced, or the amount of postage used. Wherever possible, these quantities should be derived from the actual amounts that are used rather than subjective estimates.

Outcomes in their simplest form can be thought of as the end result of the intervention as represented by changes individuals experience in physical health and social and emotional functioning. However, these outcomes can take different forms. There are outcomes that cause changes in how resources are used in the future. Effective pediatric asthma education can lead to fewer health resources needed for future asthma treatment, potentially a direct benefit of improved education.

Similarly, the therapeutic effects of a health intervention also can affect patients and their families' use of resources. For instance, parents may take fewer days off work when their child's asthma is better controlled. The therapeutic effects also can give rise to another outcome — that of changed quality of life for patients and their families. For this hypothetical asthma education project, the relevant outcome is the number of children effectively treated (e.g., the number of acute asthma attacks prevented).

Another factor to be considered is the time frame for the study. The evaluation period should be sufficient to allow the full costs and effects to be accounted for. However, it may be difficult to determine at the onset of the project how far into the future the analysis will continue. This is particularly problematic for preventive projects, such asthma education. In this case, group education may have a short-term impact on a child's asthma treatment, but future conditions may arise that negate the education's effect.

Evaluating various treatment options using an economic framework requires a thorough understanding of what costs and outcomes will be considered. By systematically applying some basic principles, the study can provide useful information about how to maximize the use of available resources. This information provides a basis from which more informed decisions can be made about the treatment of future patients. However, successful evaluations take time. Careful planning from the outset will help to ensure that all relevant data are collected accurately to allow meaningful analysis. ■

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- cite practical solutions to problems associated with the issue, based on independent recommendations from clinicians at individual institutions or other authorities. ■