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Inside: 1999 Salary Survey

INSIDE

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Outpatient woes are driving up hospital costs, length of stay

SNFs' refusal to accept high-cost patients creating 'medical gridlock'

The continuum of care concept has long been held as an ideal in the health care community, a model in which care is coordinated seamlessly across different settings. But what happens when things go wrong, when one link in the chain snaps under the pressure of changing federal regulations? According to some experts, we're in the process of finding out, as the troubles now plaguing skilled nursing facilities (SNFs) start to have a major impact for hospital discharge planners.

"Some skilled units in local nursing homes are closing," says **Deborah Hale**, CCS, president of Administrative Consultant Service Inc. in Shawnee, OK. "They were just opening in our part of the country in every nursing home" — at least before new federal rules regarding skilled facilities hit. Now, says Hale, "In the Midwest, many of the facilities are either closing their skilled beds or being very particular about which patients they accept. Of course, that tends to slow down the discharge planning process for the hospitals."

Indeed, faced with dwindling reimbursement and a spate of federal investigations, nursing homes across the country are folding in record numbers, and an increasing number of SNFs are refusing to accept high-cost patients who have been discharged from the hospital but may still require extensive care. Meanwhile, the home health industry has been similarly besieged, reducing the number of slots available for patients needing discharge to home care.

At Providence General Medical Center in Everett, WA, the problem has already hit home. Recently, members of Providence's care management team were able to discharge one patient to a nursing home only after the hospital agreed to continue paying for the patient's costly antibiotic.

The problem stems in part from the new Prospective Payment System (PPS) for SNFs, says **Chris Karam**, chief operating officer of Christus St. Michael Health Care Center in Texarkana, TX. Before last year, Medicare reimbursed nursing homes based on the actual cost of providing care.

KEY POINTS

- The financial difficulties being experienced by skilled nursing facilities because of a new Prospective Payment System and a reimbursement cap for rehabilitation services are beginning to affect the financial health of hospitals as well.
- With some nursing homes closing their skilled beds and others refusing to accept high-cost patients, discharge planners are having to scramble to find appropriate facilities in which to place patients needing ongoing care. At some facilities, discharge delays are driving up lengths of stay for patients by as much as three weeks.
- In San Antonio, one facility has brought two of its three freestanding rehab clinics back into the hospital to avoid the financial impact of the reimbursement cap, which only applies to outpatient facilities.

Last July, however, SNFs were switched to a fixed-rate system that many experts predicted would force SNFs to beef up cost-containment efforts. Even so, because Medicare doesn't cover long-term care, the federal government typically covers less than 15% of the patients in nursing homes anyway.

Cutting reimbursement in half

The real hit for SNFs came in January, when Congress imposed a $1,500 cap per patient in coverage for physical therapy, occupational therapy, and speech-language therapy. That cap effectively cut reimbursement for some types of outpatient rehabilitation services literally in half. Typically, as much as 30% of a SNF's revenue derives from such rehabilitation services.

With SNFs' increasing unwillingness to take high-cost patients, some discharge planners are having to scramble to find appropriate facilities in which to place patients who need ongoing care. Inevitably, some of these patients end up lying in hospital beds while this process takes place, driving up the hospital's length of stay.

"Of course, the longer the length of stay, the greater the financial impact," Hale says. "You're looking at a variable cost of about $290 a day for every day you wait to place a patient. You're going to add up some costs."

The costs increase even more when the Medicare patient you're unable to place requires a ventilator. At Suburban Hospital in Bethesda, MD, some ventilator patients have had their inpatient lengths of stay increased by two to three weeks because no nursing home in the area would take them, says **Sharon George**, RN, utilization and discharge manager at the hospital. With ventilator patients costing an average of $1,600 per day, an extra two weeks tacked onto the end of a normal acute care stay could cost the hospital $22,400 per patient.

And the problem of placing ventilator patients isn't likely to go away soon: Just recently, the only nursing home with a ventilator unit in Montgomery County, MD, stopped accepting new ventilator referrals altogether.

Nursing homes screen hospital patients

Nursing homes in George's area have become so cost-conscious as a result of the new PPS that they've begun sending staff to the hospital to "screen" patients prior to discharge. Much of the screening involves assessing how much the patient will cost to treat. "They want to know things like how often the patient is going for physical therapy and for how many minutes," George says. "It's all based on that $1,500 cap. They want to make sure there aren't any surprise charges when they get the patient."

While few of the nursing home representatives will admit outright that they're there to assess potential cost as well as acuity, a few have let their true motives slip, George says. "A few have said that the antibiotic the patient is on is going to cost too much, for example."

The end result, George says, is that inpatient lengths of stay for Medicare patients will ultimately increase, perhaps across the board. And it won't just be the hospitals that are affected. "I feel bad for these patients and their families," George says. "It's difficult enough for someone in the industry to understand. Try explaining to a family member why their father can't be placed."

Health systems that own both hospitals and SNFs are also feeling the pinch. For example, Karam expects that his system will lose $1.4 million in fiscal year 1999 alone thanks to the PPS changes. Meanwhile, nursing home companies themselves continue to lose money. Two months ago, Sun Healthcare Group, which owns 390 nursing homes across the country, announced that it

had failed to make a $7 million interest payment on a $150 million loan. Meanwhile, Vencor Inc., based in Louisville, KY, lost $12.4 million on its nursing home business in the second quarter of 1999. Kennett Square, PA-based Genesis Health Ventures Inc. posted second-quarter losses of $10.8 million.

Working to ensure appropriate care

To minimize losses, Christus St. Michael is working with its case management staff and with the medical directors on the system's utilization management committee to make sure the most appropriate venue for care is being used for each patient, Karam says. The system includes an 80-bed rehab hospital, a 239-bed acute care hospital, long-term care programs, day rehab programs, home health subsidiaries, and a hospice.

The hospital also is developing a request for proposals to build a referral relationship with a local nursing home in the community, Karam says. St. Michael hopes to enter a contract relationship with a nursing home that spells out expectations for quality of care and patient satisfaction. "It might be that they could take care of [some of] these patients less expensively because their cost structure is less than ours," he explains. "And it could be a win-win for them [the nursing home] to enhance their reputation in the community."

At Warm Springs Rehabilitation System in San Antonio, the hospital has brought two of its three freestanding clinics into the hospital because of the expected impact of the $1,500 cap, says **James Ashbaugh**, CHE, formerly regional director of operations for the hospital and now vice president of product management. Because these two clinics are now physically located at the hospital, they are no longer subject to the $1,500 cap. That strategy isn't feasible for the third center, which is located in Del Rio, TX, a rural community. The hospital has installed a computer system to help track spending on Medicare patients so patients can be warned if they are approaching the cap limit.

In addition, the system has talked with a nearby physical therapy practice about the possibility of referring patients to the practice once the cap is reached. The $1,500 limit is a per-facility limit, not a per-patient limit, Ashbaugh points out.

So far, patient advocacy groups have remained fairly silent about the plight of nursing homes, particularly in light of a recent General Accounting Office report that was sharply critical of the quality of care provided by nursing homes. A spokeswoman for the Washington, DC-based American Association of Retired Persons says only that her organization hasn't yet received any complaints about members having trouble getting access to nursing home care.

But that situation could change soon. Sen. Charles Grassley, who's worked in the past for home health and nursing care reform, estimates that a full 13% of Medicare beneficiaries will surpass the $1,500 therapy cap this year. That's about 750,000 people, many of whom may not be able to make up the difference out of pocket.

Payment cap could 'backfire on Congress'

Jerry Connelly, senior vice president of the Alexandria, VA-based American Physical Therapy Association, says his organization has evidence that 1% of Medicare beneficiaries already had exceeded the cap by early March. "This cap will backfire on Congress," he says, "because it will ultimately end up costing them more money. Patients who exceed the cap will take up space in nursing homes and hospitals if they don't get the therapy they need to become functionally independent."

Hope may soon be on the horizon, however. In early June, the powerful Medicare Payment Advisory Commission (MedPAC) in Washington, DC, a government body charged with advising Congress regarding Medicare issues, blasted the $1,500 cap on physical therapy benefits, calling it "arbitrary" and detrimental to the quality of patient care. MedPAC's chair, **Gail Wilensky**, released a statement saying she agreed with hospitals that Medicare is "paying too little for outpatient services."

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Staff development on a budget: What you can do

Emphasize education that benefits patients, too

With budgets tight and time scarce, it can be difficult to find ways to give staff members the opportunities they need to develop to their full potential. That's particularly true when it comes to helping case managers achieve appropriate certifications. But, experts say, there are some inexpensive techniques that can not only help staff achieve its objectives, but can also increase cooperation in your facility and improve patient care.

For example, at Prentice Women's Hospital, a division of Northwestern Memorial Hospital in Chicago, nurses and case managers are encouraged to cross-train in related departments. "I have some staff [members] who would very much like to learn labor and delivery or special care nursery, but they don't want to transfer off their home unit," says **Karen Waltenbaugh**, BSN, MS, clinical nurse manager at Prentice. "So what we've tried to do is link them up with a manager in those areas and ask if she can be fit into the schedule for a couple of weeks." Having staff work in different areas and learn overlapping skills has helped the departments work together more efficiently and created a greater sense of camaraderie among staff.

What's made cross-training successful at Prentice, however, has been making it elective rather than mandatory. No one is forced to spend time in other departments. For those who choose not to cross-train, other options for staff development are available. For example, when it became clear that a large number of patients wanted to learn infant cardiopulmonary resuscitation (CPR), Waltenbaugh encouraged staff to become certified not just in infant CPR but in teaching it to others. "We've been looking at educational opportunities in that direction, and some of them are really inexpensive," Waltenbaugh says.

Waltenbaugh also has made use of a lactation consultant to educate key staff about breast-feeding. "On quiet days, we will link them up with the consultant and let them follow her around for the entire day so they can learn tips from her," Waltenbaugh says. "We've tried to get them to the point where they're considered breast-feeding experts on the unit and are sought out by their peers to help out when there are problems. It's become a kind of peer recognition issue."

One key piece of staff development has been to encourage case management staff to achieve the certifications they need in order to advance their careers and add prestige to the department. Because of the fairly high dropout rate, Prentice doesn't pay for staff to take preparatory courses, but the hospital does pay for staff to take the actual certification test.

Once staff have become certified, it's important to support their efforts to maintain their certification. Unfortunately, some employers make it virtually impossible for case managers to do the necessary work, such as obtaining the 80 credit hours needed to maintain the Certified Case Manager (CCM) credential offered by the Commission for Case Manager Certification in Rolling Meadows, IL.

"It's to the employers' benefit to allow case managers the time and resources necessary to maintain their certifications," notes **Marcia Diane Ward**, RN, CCM, project manager in small / medium business global marketing industries for IBM in Atlanta. "The benefit is that employers go out to market their services with this statement: 'We hire only certified case managers.' Increasingly, health care organizations can't receive accreditation for their

KEY POINTS

- With the hectic schedules most case managers face, it can be difficult to find the time and resources necessary to achieve and maintain certification or engage in other staff development activities.
- One way to increase staff expertise as well as improve cooperation and camaraderie among departments is to allow staff the opportunity to cross-train in related departments.
- As far as maintaining certification, experts recommend the following steps:
  — Set aside funds early in the year to pay for conference attendance.
  — Allow staff time off to attend meetings of professional associations.
  — Allow case managers time to search the Internet for educational opportunities.
  — Provide educational opportunities in the workplace.
  — Subscribe to publications that offer continuing education hours.

case management services from national accrediting organizations unless their staff includes certified case managers."

Here are five suggestions to help case managers meet their educational needs:

1. Set aside dedicated funds early in the fiscal year to pay for conference and workshop attendance.

"Conference planners are now making concessions for the financial crunch faced by case managers," notes Ward. "Some conferences offer one-day passes, discounts for more than one attendee from the same organization, and other incentives. Don't be afraid to ask about potential discounts. Barter, if you must. No one is more creative at negotiation than a case manager; use it to your own advantage."

2. Allow time off to attend local chapter meetings of your professional organizations.

State and local chapters of national professional organizations, such as the Case Management Society of America in Little Rock, AR, offer inexpensive continuing education opportunities, Ward says. "These groups usually meet once a month, and they bend over backwards to accommodate employer schedules," she says, adding that many groups meet early in the morning or on Saturday.

3. Hire a clerical support person or give a case manager time to search the Internet for educational opportunities.

"Try to get your employer to pay a case manager overtime to gather information on the Internet and then share it with other case managers at a lunch-and-learn session," Ward suggests. "Many case managers don't have the time to surf the Internet for the many educational Web sites. Some of these sites offer continuing education credits for health care professionals."

4. Provide educational opportunities in the workplace.

For example, some organizations have begun offering programs for nurses with associate's degrees who want to advance their careers by earning a BSN, says **Deloras Jones**, RN, MS, director of divisional nursing for Kaiser Permanente California Division in Oakland. Kaiser's nursing degree program is a joint effort between Kaiser's California Division and Holy Names College in Oakland. Instead of hurrying from work to a college campus for studies, students attend classes one night a week via teleconference in classrooms at the Kaiser medical centers where they work.

Since the program began, 96 Kaiser nurses have earned their BSN degrees and 200 currently are enrolled in classes. "It takes most of our nurses two and one-half years to complete their degrees," Jones says. "Kaiser doesn't pay for nurses' tuition, but we were able to negotiate a low rate because the program is generating revenue for the college."

In addition, Kaiser offers continuing education courses for no fee or a nominal fee to its nurses on a routine basis. "It's really important for leaders in the health care industry to partner with educators to ensure the ongoing competencies of their work forces."

5. Subscribe to publications that offer continuing education hours.

Take advantage of continuing education opportunities available through professional publications. "Many case management and nursing publications offer continuing education credits," notes Ward. It's not as stimulating as networking with your peers at conferences, but if your organization doesn't allow you time off to attend professional meetings, these publications may be a viable option for you.

"Case managers must reclaim their autonomy as professionals," Ward urges. "Your employer needs you to maintain your certifications and professional licenses, and that requires continuing education. Explain [to your employer] that continuing education is not an option — it's a necessity."

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Is your discharge planning process really effective?

Survey discharged patients to find out

Too often, case managers discharge patients from acute care without ever finding out whether the education those patients received in the hospital really prepared them for the next stage of their treatment. Aware of that problem, case managers and administrators at Fairview University Medical Center in Minneapolis decided to construct a survey that would help them find out just how effective their discharge planning efforts had been.

KEY POINTS

- To evaluate the effectiveness of its discharge planning process, Fairview-University Medical Center in Minneapolis distributes a survey to 200 patients each week, asking them whether they had a better understanding of their illness at discharge than when they entered the hospital, whether hospital staff prepared the patient for proper home care, and whether the patient felt he or she was sent home too quickly.
- The hospital's Patient Learning Center also randomly calls 10 to 15 patients each month to find out how they're managing their care after discharge.
- To ensure that patients leave the hospital with the skills they need to succeed during the next phase of their care, experts recommend testing patients before they leave by challenging them to perform the skills they will need to use. Practicing in the hospital gives case managers the chance to evaluate the patient's level of understanding and problem-solving ability.

Now, with the help of the patient relations department, a multidisciplinary team distributes a specially prepared patient satisfaction survey to 200 patients each week, asking the following three questions:

• **When you left the hospital, did you have a better understanding of your illness than when you entered?**

• **Before you were discharged, did the hospital staff prepare you or your caretaker to manage your care at home?**

• **Were you sent home from the hospital before you felt ready?**

The Patient Learning Center at the hospital, which provides individual instruction for patients and family members, also randomly calls 10 to 15 patients a month to ask how they are managing their care after discharge. "We are specifically interested in knowing whether they received all the information they needed to safely care for themselves on their own," says **Nancy Goldstein**, MPH, patient education program manager at Fairview-University Medical Center.

The nurses who make the calls also ask about the consistency of the information the patient received while in the hospital and whether the information was easy to understand. The hospital tried mailing the surveys and also giving the patients a questionnaire before leaving the hospital, but those methods were not satisfactory.

"Patients did not return the mail surveys, and we did not get the information we wanted from patients that hadn't been at home for a while managing on their own," explains Goldstein.

The best way to evaluate the effectiveness of discharge planning is through conversation, says **Fran London**, MS, RN, health education specialist at The Emily Center at Phoenix Children's Hospital. "You find out if a patient is ready for self-care upon discharge by asking," she explains.

However, questions should be specific rather than general. Have the patient demonstrate understanding, she advises. For example, rather than asking patients if they understand what they were taught and if they are ready to go home, ask them to explain the signs and symptoms of infection and how they would respond should one occur.

"Offer a scenario of something that could go wrong after discharge, such as missing a dose of medication, and ask the patient what he or she would do in that situation," suggests London.

To determine if patients will implement the plan of care, such as a change in diet, ask how they will go about making the changes. Also ask what will make it difficult to implement the plan and how the patient will deal with that difficulty. "If the plan was imposed rather than mutually agreed upon, the patient may not know how to modify it to fit into his or her lifestyle," London explains.

When patients must learn skills for appropriate self-care at home, the best way to evaluate their learning is to watch them demonstrate the skills. It's best if patients practice the skill several times during hospitalization. This not only provides practice; it gives the nurse or case manager an opportunity to evaluate the patient's understanding of the process and ability to problem-solve should something go wrong, says London.

Evaluating a patient's learning before he or she is discharged is a good way to determine if the education was appropriate, agrees **BJ Hansen**, BSN, patient education coordinator at Grant/Riverside Methodist Hospitals in Columbus, OH. Nurses at the hospitals are instructed to ask specific questions, such as: "What would you do if your incision was red?"

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CRITICAL PATH NETWORK™

Psychiatric hospital's discharge planning streamlined

By **Cynthia Leslie**, RNC, CCDC, MSN
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Good Samaritan Hospital in Downers Grove, IL, developed diagnosis-driven critical pathways for inpatient and outpatient psychiatric services. These paths were developed to assist in discharge planning and to ensure patients were following a continuum of care that met their needs. Identified variances that could affect length of stay and outcomes of care also were implemented and tracked with the paths. **(See *Hospital Case Management*, August 1994, p. 135.)**

Since 1994, unit case managers have been overseeing the critical pathways and the variances of each hospitalized patient. Case coordinators / utilization review nurses have been monitoring and tracking variances in terms of effects on length of stay, issues in overall care / management of the patient, and integration of support systems and transitions to the next level of care.

The intensity / level of care and continuity of services were stressed in developing a solid discharge plan from inpatient to partial to outpatient services. However, recidivism continued. Patients continued to return to inpatient units rather than utilizing a less resource-intensive environment in the partial hospital.

The Clinical Practice Committee, composed of case managers and utilization review nurses, developed a patient satisfaction program. The resulting patient satisfaction plan consisted of three actions, which were subsequently implemented. The first action was investigation. For this phase, a questionnaire was developed and used on a weekly basis by case managers to call patients at home to assess whether the following conditions were met:

1. The patients were following their post-discharge plans made prior to being discharged from the inpatient program.

2. The patients were keeping their initial post-discharge visits with their psychiatrist.

3. The patients were compliant with the medication therapy individually prescribed for them by their psychiatrist.

4. The patients were using their identified support resources since being discharged and whether these resources had been helpful to them, such as AA, NA, PHP, DDA, Crisis Center, support groups, or other self-help groups.

Other investigative questions were asked to gather additional information. These questions were more specific to the patient's present condition and addressed how the patients were presently feeling and whether the patients were functioning better than they were prior to admission. We asked the patients what they had learned in therapy that was most useful to them today and what contributed most to making their hospital stay comfortable.

After completing the investigative phase, we began the interpretation phase. By using the information gathered, we were able to determine whether the patients were following their discharge plans. If they weren't, what were the causes? We were able to track whether patients were able to continue therapy with their psychiatrist on an outpatient basis after discharge and what contributed to their compliance or lack of

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Patient Workbook Excerpt

ISSUES FOR CONTINUED WORK

Issues I have identified that contribute to my illness. (Include feedback from family, therapist and doctor.)

1.

2.

3.

4.

What steps can I take to work on these identified issues.

1.

2.

3.

4.

What would prevent me from following through and working on these issues?

1.

2.

3.

4.

Source: Good Samaritan Hospital, Downers Grove, IL.

Patient Workbook Excerpt

SELF ESTEEM

To be a healthy, responsible person, I must learn to take good care of myself first.

A. I've been told that some of my strengths are:
   1.
   2.
   3.
   4.

B. What I really like about myself is:
   1.
   2.
   3.
   4.

C. What I learned about myself during my stay here is:
   1.
   2.
   3.
   4.

D. To stay healthy, I need to always remember that:
   1.
   2.
   3.
   4.

E. To keep my self-esteem in tact, I need to always remember that:
   1.
   2.
   3.
   4.

Source: Good Samaritan Hospital, Downers Grove, IL.

(Continued from page 123)

it. For patients who were prescribed medication therapy, we sought to learn what was most helpful to their efforts to take their medications as prescribed by their psychiatrist. If patients were not using the community resources available to them, we attempted to ascertain what was hindering them from doing so. We also began to evaluate what was most helpful to them in meeting their goals for discharge during their hospitalization. Was it group therapy, one-on-ones, or another therapeutic intervention? How did they rate our program? Did it meet their needs? If we had to change anything, what would they recommend? Are they utilizing their individualized discharge plans and are they doing well?

After completing the interpretation phase, we were ready for the intervention phase. During this phase, we gave positive feedback to patients who were doing well and who demonstrated that they were continuing to work toward improving their well-being. We encouraged those who suggested they might be relapsing to call their doctors to see if they needed a medication adjustment. Or we tried to problem-solve to determine if the patients were committed to taking their medication and had been utilizing community resources available to them. At times, we suggested that they visit intake for an assessment to help determine which interventions would best meet their needs. Information gathered through call-backs was then used to review our current program to determine if it continued to meet the needs of patients.

A Discharge Planning Continuous Quality Improvement Committee was formed to address patient needs regarding the discharge process. The multidisciplinary committee was composed of nurses, social workers, a clinical nurse specialist, a unit nurse manager, and case coordination nurses. Input for the committee was provided by inpatient and outpatient staff. Our goal was to develop a continued focus on discharge planning in the treatment process.

A more complete patient workbook was developed. This workbook's purpose is to provide resources a patient could use through the continuum of care in the hospital and out of the hospital. This workbook would be used by the patient during inpatient status and continue to be used through the continuum of care in the lesser levels of treatment. The contents included financial concerns, issues for continued work, relaxation, supports and resources, medications, affirmation sheet, aftercare plan, and resource list.

On a daily basis, staff discuss this workbook with the patients in their small groups on the unit. The book also is used for the discharge group led by our social worker, which follows patients during their continuum of treatment.

Now, when case managers call the discharged patients to assess whether they are following their discharge plans, case managers can ask the patient if the daily workbook was of assistance to them.

Discharge planning is one of the most important aspects of health care today. It is important that patients are aware of obstacles they might meet that could influence their discharge plans and treatment. Our committee wanted to give the patient a book that was as detailed as possible. Patients having their own written information available to them after discharge during a time of crisis seemed to be the best solution.

The Discharge Planning Group will continue to meet on a weekly basis and elicit feedback from staff and patients regarding the effectiveness of the discharge workbook. The group will continue to evaluate and revise the workbook as needed based on the feedback the case managers receive from patient callbacks. It also will be important to continue to monitor the workbook's effect on length of stay, inpatient recidivism, compliance with treatment, and improved use of support services.

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The depth of the follow-up and evaluation, however, should depend on the diagnosis, says Hansen. A person who has general surgery will usually not need to learn that much for a safe discharge, while a cardiac patient could require a lot more education. For example, patients who have had open-heart surgery receive a follow-up call seven days after discharge and are asked questions about their condition. These questions include:

- **Have you had any ankle or foot swelling?**
- **Do you have any questions about activity instructions?**
- **Are you following your walking schedule?**
- **How many minutes are you walking?**
- **Do you have any questions about your medication?**

Patients diagnosed with a chronic disease that requires lifestyle changes are referred to outpatient programs for detailed education. "In the acute setting, people are so sick and are hospitalized for such a short period of time that they are overwhelmed with a lot of different information. For lifestyle changes, we would like them to come in as an outpatient," says Hansen.

For example, it is much better for a patient to come back a week later for a consult with the dietitian and spend one or two hours going over the information than to receive extensive diet instructions before discharge.

Many of the outpatient courses patients are referred to provide detailed teaching, and the teaching is evaluated to determine if it is effective. "We do more extensive follow-up on our more extensive programs," says Hansen.

For more information on evaluating the effectiveness of your discharge planning, contact:

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CABG path cuts recovery LOS to one post-op day

Ventilation time is cut from 12 hours to six

Timing was everything when it came to developing the successful coronary artery bypass graft (CABG) pathway at St. Francis Hospital and Health Centers in Beech Grove, IN.

Five years ago, members of the cardiac team proposed the idea of pathways to the cardiac surgeons with whom they worked. "We said, we really want to do pathways, they're the wave of the future," says **Kathy Fox**, RN, MSN, cardiac service line director at St. Francis. The response they got back was typical: "They gave us the same old story about it being cookbook medicine. They still had that perception."

Two years later, however, the situation at St. Francis had changed so drastically that the physicians themselves were requesting that pathways be developed, Fox says. "When we started talking to managed care companies and getting cardiac carve-outs, everybody started asking, 'What about pathways?' Because that was the buzzword," Fox says. "Then physicians were coming to us and saying they really needed those pathways."

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KEY POINTS

- An early goal of the cardiac service line team at St. Francis Hospital and Health Centers in Beech Grove, IN, was to reduce the postoperative recovery time of coronary artery bypass graft patients in the Cardiac Surgery Unit (CSU). Previously, recovery time had averaged two to three days, while the room rate in the CSU runs about $1,200 per day.
- Now, with the help of a pathway originally based on existing preprinted orders created by the cardiac surgeons, the service line has decreased recovery length of stay to one day, with 80% to 90% of patients moving out on postoperative day one.
- Eventually, the cardiac line staff hope to combine the recovery area and the step-down unit so it's not necessary to transfer patients and maintain two separate staffs.

CLINICAL PATHWAY ST. FRANCIS HOSPITAL & HEALTH CENTERS
Beech Grove, Indiana

Patient Name: _____ EDP #: _____
Initial Visit Date/ Time _____ Surgical Procedure: _____ POD _____ at Discharge
DRG: ☐106 (CABG with cath) ☐107 (CABG pre-admit cath) ☐104 (Valve with cath) ☐108 (Other Cardiothoracic Procedures)
☐105 (Valve pre-admit cath)Other
Allergies: _____ History _____
Primary Physician: _____
Consults: _____

	DATE: VISIT: **Admission**	DATE: VISIT: _____
INTERDISCIPLINARY FOCUS Provide self-care management strategies related to life style changes including medications, diet, activities, incision care, CAD process, and referrals **Date** _____ **Initial** _____	**OUTCOME GOALS** ___ Identifies adverse signs & symptoms to report ___ Verbalizes need to call 911 (and or other emergency numbers) in an emergency ___ Explains correct medication schedule ___ Demonstrates safe use of equipment ___ Explains plan of care and expected length of service ___ Verbalizes understanding of home walking program	**OUTCOME GOALS** ___ Exhibits no new or worsening symptoms ___ Verbalizes purpose, action, side effects of each medication ___ Verbalizes general diet ___ Verbalizes acceptable activity level ___ Takes pulse/blood pressure correctly ___ Incision: No signs or symptoms of infection/ complication
CONSULTS	___Assess need for PT/OT for assistance with ADL's and/or Home Rehab program ___ Assess need for Social Services ___ Assess need for Speech Therapy ___ Assess need for HHA to assist with ADL's	___Assess need for Smoke Stoppers
DIAGNOSTICS	___BIOX prn ___EKG prn	___Protime (valves) 2-3 days post discharge ___BIOX prn ___EKG prn
TREATMENTS/ASSESSMENTS **Call Orders:** Temp > 101.5 **Incisions:** Redness beyond incision line warm and tender to touch	___ Assess incisions ___ Wound/skin assessment ___ Assess sternum for stability ___ I.S. QID ___ TED Hose on ___ Weigh daily ___ Nursing clinical assessment ___ Dressing change prn	___ Assess incisions ___ Wound/skin assessment ___ I.S. QID ___ TED Hose on ___ Weigh daily ___ Nursing clinical assessment ___ Assess sternum for stability ___ Dressing change prn
MEDS	___Verify correct medications are in the home ___ Establish basic medication schedule in writing and leave in home ___ Assess resumption of pre-op medications	___Review medication schedule ___ Assess for medication changes
NUTRITION	___ Assess for nutritional and hydration status ___ Diet modifications if appetite poor ___ Fluid restrictions (if applicable)	___ Assess for nutritional and hydration status ___ Assess compliance with fluid restrictions (if applicable)
ACTIVITY	___ Assess functional status ___ Assess ability to perform ADL's ___ Assess home walking program	___ Assess functional status ___ Assess ability to perform ADL's ___ Assess home walking program
EDUCATION/HOMECARE PLAN	___ Provide emergency phone numbers ___ Instruct on pain management ___ Instruct on use of equipment ___ Instruct on home walking program ___ Instruct on medication regime ___ Instruct on wound care ___ Instruct on taking pulse ___ Instruct on diet	___ Instruct on wound care ___ Instruct on taking pulse ___ Instruct on diet ___ Instruct on pain management ___ Instruct on use of equipment ___ Instruct on home walking program ___ Instruct on medication regime

Signature	Initial				

I understand that this plan of care may change based on my medical condition.

PM5.CP_HH-CS.PM5
8/8/97

Reviewed plan of care with Patient
Patient/S.O. _____ **Case Manager** _____ **Date** ____/____/____

Source: St. Francis Hospital & Health Centers, Beech Grove, IN.

CLINICAL PATHWAY

ST. FRANCIS HOSPITAL & HEALTH CENTERS
Beech Grove, Indiana

Admission Date/Time: _____ Diagnosis/Chief Complaint _____
DRG ❑**106** (CABG with cath) ❑**107** (CABG pre-admit cath) ❑**104** (Valve with cath)
❑**105** (Valve pre-admit cath) ❑**Other**
Target LOS ❑5 ❑7 Allergies _____
History _____
Primary Physician: _____ **DNR: Y N Advance Directives: Y N**
Consults: _____

Patient Identification

CARE CATEGORIES	DATE: DAY: Pre-0p	DATE: DAY: DOS
INTERDISCIPLINARY FOCUS Facilitate optimal recovery in desired time frame by providing education resources and referrals during peri-operative period. **Date** _____ **Initial** _____	**OUTCOME GOALS** ____ **Patient/Family able to describe need for surgery, pre-op procedures, and realistic expectations of recovery.** ____ Provide teaching materials ____ Offer unit tour	**OUTCOME GOALS** ____ Achieves stable hemodynamic and fluid balance ____ **Achieves stable heart rhythm** ____ System assessments are within normal limits ____ **Extubated** ____ Diet advancement ____ Pain Control
CONSULTS	____ RT for PFTs (Pre-Op O2 Sat _____)	
DIAGNOSTICS: Dailies	____ Coag screen. Do not repeat labs drawn in past 24 hours. ____ Patients < 70, T&C for 2 units PRBCs ____ Valve patient, CABG redo, patient > 70 T&C for 4 units PRBCs, 8 units platelets ____ PA & Lat CXR - call report ____ EKG ____ CBC, UA, Chem 7, Hepatic Profile, CPK ____ All results on chart by 3 p.m. and on pink pre-op checklist* ____ Abnormals called	____ STAT: ABG, Hemogram, Chem 7 ____ Stat BS CXR ____ K+ prn ____ ABG per anesthesia protocol
TREATMENTS/ASSESSMENTS **Daily Weight** **Call Orders:** **SBP** < 100 or >160 **U/O** <30 cc/hr **Pulse** > 130 or < 60 **T** > 39 C° **CTD** > 200cc /hr **CVP** >15 or < 5 **Arrhythmias N/V, Resp distress** **C.I.** < _____	____ VS - BID ____ Daily Weight ____ Hibiclens bath/shower in p.m. ____ O_2 2-4 L NC after pre-op meds ____ Fleet enema in p.m. ____ Old chart to floor then to OR with patient ____ Surgery Consent ____ Anesthesia Consent ____ Blood Consent	____ NG to LCS - irrigate with 50cc NS q 4 hr and prn discontinue when extubated ____ If CVP < 5, in first 8 hrs post-op give 500cc NS and call MD ____ Foley to dependent drainage ____ Urine rep. D5.45 NS 1/2cc for every 1 cc U/O over 200 cc/hr ____ CT underwater seal - 20 cm sx ____ Apply TEDS in a.m. ____ Check pedal pulses per protocol ____ Incision care per protocol ____ VS: CTD q 15 minutes until stable ____ C.I. q 1 hr X 4, q 2 hr X 4, Then q 4 hr if stable ____ I &O q 1 hr, Neuro checks q2 or more frequently as indicated
RT		Vent: Per protocol / orders RCA: after extubation O2 _____ IS _____
MEDS Total Blood Products given: RBC _____ Platelets _____ FFP _____ Cryo _____ Other _____		____ Maintain IVs at 50 cc/hr total: CVP - 1000 cc D 5 .2 NS 40 mEq KC1 at not less than 10 cc/hr ____ Other IVs TKO with D 5 .2 NS or IV lock ____ Maintain PA/aline 500 cc NS with 1000 units Heparin
NUTRITION	Cardiac ____ gm Na diet ____ ____ NPO after midnight	____ Ice chips and clear liquids po 2 hours after extubated unless otherwise indicated
ACTIVITY	____ Up ad lib ____ Pre-op Activity	____ Raise HOB 30 degrees ____ Turn q 2h ____ **Dangle when stable 5 - 10 min**
EDUCATION/DISCHARGE PLAN	___ Pre-op Teaching ___ Review Patient Pathway	___ Unit Environment ___ Vent wean/Extubation ___ Activity

PM5.CPCSUa
Printed on 12/3/98

Signature	Initial						

Reviewed plan of care with PT/ SO (Sign.) _____ Reviewer (Sign.) _____

Source: St. Francis Hospital & Health Centers, Beech Grove, IN.

(Continued from page 127)

The movement to create a CABG pathway gained steam when hospital management implemented eight service lines divided by diagnosis-related groups.

"To go to the service line concept required an entire redesign of how we provide care to patients," explains **Jerri Devaney**, RN, a cardiac service line care manager at St. Francis. "With that in place, we went to work on our length of stay. Back then, our patients stayed two and a half or three days. [Our goal was] a one-day stay in recovery, so we had some work ahead of us to make that happen."

"If we were going to decrease length of stay in the recovery unit, the staff in the step-down unit needed to be prepared to take care of those patients," says Fox. For that reason, she initiated staff cross-training in Levels 1 and 2 of the cardiac surgery unit (CSU) — the open-heart recovery unit and the step-down unit. "We sat down with the physicians and administration and said, '[Decreased length of stay] is what we want to achieve; this is how long it will take to do it.' We told them that we needed to cross-train all the staff in the step-down unit to CSU Level 1."

Devaney points out that when you decrease the length of stay (LOS) in higher acuity levels, you substantially decrease cost. The room rate for the CSU Level 1 is about $1,200 per day.

When it came to designing the CABG pathway, Fox and her colleagues didn't have to start from scratch. The physicians who had originally resisted the pathway concept were already using a lot of preprinted orders and protocols, to the extent that most pathways already followed a sort of informal pathway, says **Kelli Kappus**, RN, BSN, CCRN, manager of the CSU Levels 1 and 2.

"Our starting point was to take what we already had as far as their preprinted routines for all patients, set these against a time frame, and then develop a pathway," Kappus says. "We used that as a starter, then set goals for what we wanted to achieve." Some of those goals included transferring the patient from the CSU on the first postoperative day, ambulating the patient on the same day, and discharging the patient on postoperative day four. **(See sample pages from the pathway, pp. 128-129.)**

The service line has decreased recovery LOS to one day (80% to 90% of patients move out on post-op day one). Because of that, the hospital is going to open up some ventilator beds in the unit. The reason most patients don't transfer out of the CSU on the first post-op day is because pulmonary problems often exist and need to be monitored; therefore, the patients must stay longer.

Another goal was to extubate patients earlier, in accordance with accepted national guidelines. To achieve that, the staff had to promote change in the anesthesia department's protocols on providing short-acting medicines. "We went from a 12-hour to a six-hour ventilation time," says Devaney. "Patients do better on shorter time, because staying on the ventilator overnight is not good for the respiratory system. When patients are extubated sooner, their risk of pneumonia is decreased, as well as problems like phlebitis."

However, she says, there is a point at which you can safely and cost-efficiently push the envelope, and a point at which you have to stop. "That's where we are now with our ventilator hours. We've decreased them to six, and we haven't seen an increase in our reintubations."

St. Francis occasionally has patients who can move out of the CSU the evening after their surgery — as quickly as six to seven hours after minimally invasive surgery.

"There may be opportunity for improvement there," says Fox, "but we have to be cautious and monitor those cases. You don't want patients coming back because they've been moved out too quickly." The cardiac department has decreased its LOS without increasing readmissions to the unit.

The ultimate goal of the cardiac line staff is to eventually have the recovery area and the step-down unit combined. "Our goal is to not have to transfer patients at all," says Fox. "It's not efficient to have two separate units and two separate staffs."

With a reduced LOS, the cardiac team finds that some patients need more time for education than is possible during their short stay. St. Francis provides pre- and postoperative housing and

training for patients and family that provides a transition to home.

"Education nurses there go over rehabilitation, incision care, when to call the doctor, and other matters so the patients and families understand completely what's going on," says Devaney. "Some readmissions occurred because patients didn't understand some aspect of their care when they were discharged. That may be the result of anxiety, or perhaps they were under the influence of their pain meds." Sometimes, she explains, a patient is on a medicine preoperatively, but doesn't realize that his post-op meds may be the same but have a different name. There's a risk of doubling up.

St. Francis operates 480 to 540 beds and comprises two hospitals and two clinics. The facility did 525 hearts — bypasses and valves — and 3,800 caths and interventions in 1998. There are three large competing heart programs in the Indianapolis area, where St. Francis is located.

For more information about the CABG pathway at St. Francis, contact Kathy Fox, RN, MSN, cardiac service line director, St. Francis Hospital and Health Centers, 1600 Albany St., Beech Grove, IN 46107. Telephone: (317) 783-8367. ■

More cyber news: Records privacy concerns patients

There's little doubt that Americans are commuting daily on the information superhighway. For case managers, the commute presents both opportunities and threats for themselves and their patients.

For example, a recent survey conducted for the California HealthCare Foundation in Oakland found that Americans trust their doctors and hospitals with confidential medical information, but they fear disclosure when that information is handled and stored by private health insurance plans. Computerization and electronic transfer of medical records were seen as the most serious threats to medical privacy by the 2,100 consumers surveyed.

Other findings include the following:

- 54% of respondents said they believe the shift from paper record keeping to computer-based systems makes it more difficult to keep medical information confidential.
- 55% said they worry about computer hackers breaking into electronic medical records.
- 30% said they worry about authorized users leaking private medical information.

An unrelated survey on health care managers' Internet use conducted recently by Cut to the Chase, a health care management information firm in Watertown, MA, found that when it comes to racing down the superhighway, managers in acute care settings are way out in front.

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Asked about their Internet access at work, only 37% of managers in long-term or subacute care reported having access, compared with 76% of their colleagues in acute care settings. Other findings include:

• 73% of managers in medical practice groups reported having Internet access at work, compared with 57% of managers in home health.

• 43% of home health managers and 60% of long-term and subacute care managers report having Internet access at home only.

For more details on the Internet study, visit the company's Web site at www.cuttothechase.com or call (617) 926-3177. ■

Survey finds patients want to be told the truth

Press, Ganey Associates in South Bend, IN, recently compiled data from 250,000 patients in 476 hospitals and found that the majority wants the cold, hard facts about life support and organ donation.

"When health care organizations share information regarding life support options and organ donations, what they are doing is admitting the possibility of an adverse outcome. While it was once believed that patients would cringe during a discussion relating to the possibility of mortality, the truth is that by doing this, health care organizations are creating a collaborative atmosphere that empowers the patient," says **Irwin Press**, PhD, president of Press, Ganey. "The results of this study clearly show that by bringing patients into the reality of health care, we're serving and satisfying them — not intimidating them."

The survey questionnaire asked patients whether the hospital provided information on organ donation and on the choices available for continuing life. The survey found:

• 85% of patients who received information about life-continuation options were satisfied with their care provider, compared with 81% of patients who did not receive information about life continuation options.

• Nearly 86% of patients who received information about organ donation were satisfied with their care provider, compared with roughly 82% of patients who did not receive information about organ donation.

"When we look at the satisfaction of patients who tell us they received information of this sort, it is clear that their assessment of the health care experience does not diminish," Press says. "Instead, patients who report receiving information are significantly more satisfied than those who did not."

(Editor's note: For additional information, visit Press, Ganey Associates' Web site at this address: www.pressganey.com.) ■

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. ■