HOSPITAL CASE MANAGEMENT™

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

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Concurrent review initiative helps NC hospital cut avoidable days

Proactive approach keeps denials low

Before the case management department at Northeast Medical Center in Concord, NC, launched an initiative to cut down on denials, the hospital's rate of avoidable days was as high as 12%.

Now, 2½ years later, avoidable days have dropped to 8%, according to **Dianne Hansford**, RN, MSN, director of case management at the 475-bed hospital.

Northeast Medical defines avoidable days incidents as patients who do not meet admission criteria or those who had delays in treatment and discharge. "We wanted to avoid denials and delays in treatment and to improve our processes and procedures. We started by identifying barriers that impact discharge and compiling the major reasons for avoidable days," Hansford says.

The case management department at the hospital includes utilization review and case management. Some case managers perform traditional case management duties while others primarily perform utilization review activities. "We are very keen on identifying and eliminating potential barriers to care," she says.

Concurrent denial management

Using the MIDAS+ care management system software from Dallas-based Affiliated Computer Services Inc. (ACS), the case management department began monitoring avoidable days.

The case management staff concurrently review about 90% of Medicare patients, all requested privately insured patients, as well as Medicaid and self-pay patients to determine avoidable days.

"We review the majority of patients in the hospital," Hansford says.

The case management department performs concurrent review and concurrent denial management every day, adds **Jo Ellen Inman**, RN,

BSN, MBA, utilization review case manager. "We take a proactive approach to avoidable days, and that is one reason we are able to keep our denials and avoidable days so low," she adds.

As a utilization review case manager, Inman reviews all insurance requests within the same calendar day, unless the patient is having a procedure, then she conducts the review within 24 hours.

Inman sees all patients and reviews all charts within three days. "We have to be proactive and not reactive. Once a Medicare denial occurs, it's not recoverable."

The utilization review case managers typically do not interact with the patients. Instead, they call on the physician-based case managers when a question arises.

Finding avoidable days

"As a utilization review case manager, I see what is on the paper, what the payer will see. I have that perspective, but I also can interact in real time with the case managers [who see the patients in person and] who have the real picture and the ability to interact to minimize avoidable days," she adds.

In many cases, the problem that Inman picks up on is simply an issue of having the physician document or go into more detail on the chart. "But having another set of eyes, another clinician, review the case also serves as a quality check in case something has been overlooked."

The case management department sends regular reports to the hospital's resource utilization subcommittee and gives input to the medical staff on patients who didn't meet InterQual (McKesson Health Solutions, Newton, MA) criteria or when treatments or protocols aren't followed.

Each case manager reviews her cases to find avoidable days every week and turns in an avoidable days report. The department reviews each case manager's report as a team to make sure there is a consensus that the information is valid and that the days could have been avoided.

Initiatives launched

When there are gray areas, the case management team goes to the resource utilization committee, asks it to review the incident to determine if it agrees there was a problem, and asks for suggestions on how it could be solved.

"We may say this patient could have been treated as an outpatient or in a different arena," Hansford says.

Every three months, Hansford's department takes a close look at trends in delay in treatment and denials to determine if there are specific areas where problems occur.

"We work so closely with doctors that we have to look for the little problems, not the big problems. The physicians have done a good job in appealing denials, so the denials aren't a big problem," she says.

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Editorial Questions

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After reviewing the avoidable days, the case management department launched a series of initiatives to help avoid them.

The case management staff alert physicians and physician-based case managers whenever avoidable days occur to help them recognize and avoid future problems.

This includes patients who didn't meet the admission guidelines as well as those who could be discharged to a less intensive setting than a hospital, Hansford adds.

Staff zero in on specific problems and take steps to correct them. For instance, when the case management department looked at unnecessary admissions to the intensive care unit (ICU), it focused on patients admitted with gastrointestinal bleeding.

"We looked at the reasons for admission and found out that several people were being admitted to the ICU when they didn't need to be in there based on their blood work," Hansford says.

Reasons for admission

The case managers took their findings to the resource utilization subcommittee, which includes physicians, and helped rewrite the protocol for gastrointestinal bleeding. "Now we look at mental status, orientation, how stable they are, and how much blood has been lost instead of using just the blood work as the criteria," she says.

If a patient with gastrointestinal bleeding has hypertension, he or she still may be admitted to the ICU, but if the patient is stable, he or she is sent to the medical unit with orders to be monitored closely. When the committee examined the

Initiatives reduces extra days, unnecessary admissions

Hospital sends patients directly to assisted living

To alleviate the problem of "social admissions" from the emergency department (ED), Northeast Medical Center in Concord, NC, established an ED case management staff and made arrangement with local assisted living facilities to admit patients directly from the ED.

For instance, a family member may bring a patient to the hospital and say the patient is weak, won't eat, and the family can no longer take care of him or her. The patient doesn't need to be admitted to the hospital, but the family doesn't feel comfortable taking him or her back home.

Patients who live alone may come to the ED with a broken bone. They are medically stable but have no one to help them with their activities of daily living.

"These are patients who don't have severe medical conditions that require hospitalization, but there are multiple reasons that their families can't take care of them. It's mostly a social issue and not a medical issue," says **Dianne Hansford**, RN, MSN, director of case management.

The ED-based case management staff have worked with assisted-living facilities in the area and provide them with the paperwork to admit the patients. The team includes both social workers and case managers who work with patients who come into the ED.

"We have someone on call 24 hours a day. We've sent people to assisted-living facilities in the wee hours," Hansford adds.

The case management staff talk to patients and families about their options if they can't be cared for at home and don't meet the qualifications for hospital admission.

If the patients don't have Medicaid to pay for assisted living, the case management staff help them locate a sitter or home health care.

Patients who are eligible for assisted living generally don't meet the medical necessity guidelines for Medicare to pay their expenses and must pay them out of pocket. "We give them all the options and let them make an informed decision," she says.

The case managers encounter one or two patients each month who refuse to leave.

Sometimes, they are fearful of being discharged without on-the-spot medical care available. In other cases, the family is not prepared to care for them at home, Hansford says. When a patient refuses discharge or placement at another facility, the social workers begin working closely with the patient and the family. "We tell them they will be responsible for the bill, based on Medicare guidelines for noncoverage," Hansford says.

The social workers help ease the transition by working with family members to assure them that the patient no longer needs acute care and helping them become comfortable with discharging the patient to home or another level of care.

"A lot of it is upfront work. One of the things we monitor is a patient's perceived readiness for discharge," Hansford says.

The case management department works closely with the hospital's director of patient satisfaction to see if the patients report on their post-discharge surveys that they were ready to go home.

"We are working with the patient satisfaction staff and the physicians to identify how we can better prepare patients for discharge," she says. ■

data again, there was a significant improvement.

The case managers look closely at all ICU patients, reviewing guidelines and criteria and checking the patient charts. "For instance, if coronary care patients' heart rhythm is stable and they're not having any problems, they could go to the medical-surgical unit," Hansford says. When case managers encounter patients who could be at a lower level of care, they talk to the physicians, get the documentation, and work to make sure patients meet the severity of illness criteria.

"We look very carefully at the charts. Sometimes, there is no documentation to support the current level of care. We then talk with the physician, and if there still is no justification, we conclude that the patient could have been at a less intensive level of care or not been there at all," she says.

Addressing documentation

The team worked to determine why delays in treatment and procedures were occurring. It looked at whether the delays with various diagnoses were caused by problems with the admissions guidelines or treatment guidelines.

For instance, one problem was a delay in surgery for cardiac catheterization patients who were admitted on Saturday and had the catheterization procedure on Monday. The team compared the cost of the delay for the treatment and the cost of doing cardiac catheterizations on Saturday.

"We did a cost-benefit analysis and determined that there was not significant enough savings to call a team in on Saturdays except in the case of imminent need or an emergency," she adds.

Many of the avoidable days were due to patients who needed to be admitted but were admitted under the wrong status. For instance, physicians would admit patients for observation; however, for the hospital to get appropriate reimbursement, they should have been admitted on an inpatient basis, Hansford says.

To alleviate the problem, the case management team created pocket cards for the physicians based on InterQual parameters of care for observation vs. inpatient admission status.

"It helped the physician to better understand the level of care patients needed to be admitted under. We still work with them closely and work with the emergency room staff on point-of-entry case managers," she says.

Lack of documentation or inadequate documentation to support severity of the illness is another frequent problem. When this occurs, the case managers give the physicians suggestions of what would support medical necessity. They point out what needs to be documented for reimbursement purposes.

The hospital has established a compliance documentation program that looks at what a patient is being treated for and how it is worded on the chart. It looks at whether the patient has an acute care plan and what is anticipated post-surgery, such as a possible postoperative hemorrhage.

"We work with other agencies that grade the hospital, based on coding. Coding is based on documentation. We know how critical documentation is, and we are focusing on improving it," Hansford says. A close working relationship with the physicians is a key to cutting down on avoidable days, she points out. "Our case managers are physician-aligned and have an incredible working relationship with the medical staff."

The case managers work with the physicians on other options, such as performing some diagnostic procedures on an outpatient basis. They look at criteria and point out what the orders should be to prove medical necessity. For instance, a patient with a stroke must have orders for neuro checks.

"Most of the problems we find are little things. Often, we find that the patient needs to be here but the physician must write certain things into the record. We keep reminding the physicians that we have to prove why the patient is here and what treatment we are doing to justify keeping them here," Hansford adds.

Ongoing relationship

When the hospital gets a denial, staff look at why the patient was admitted and what should have been documented to meet medical necessity. They take the information to the physician.

"We have an ongoing relationship with the physicians, and there is an element of trust and rapport between them and the case managers. It's not like we are policing them or trying to manage the care of their patients. We are helping them to better document the severity of illness of their patients," she says.

Inman came to Northeast Medical Center from another hospital where she worked on the denial recovery team. She gives kudos to the administration at Northeast for putting the resources behind the case management team.

"You have to put in the labor expenses before you can see the financial benefits of managing avoidable days," she adds. ■

Hospital uses team approach for CM, UR

Redesign of department is a work in progress

Before Thomas Hospital in Fairhope, AL, redesigned its case management program, nurses from two separate departments — social services and utilization review — performed case management-type functions.

At that time, the social workers and RNs in the social services department handled discharge planning and provided support for patients and families.

The registered nurses and licensed practical nurses (LPNs) in the case management/utilization review department performed utilization review and were beginning to conduct case management on a trial basis.

In 2002, the hospital hired a division director to redesign its case management program and oversee the social work, discharge planning, and utilization review functions. "The first step was to reduce the amount of duplicated work," says **Carolyn Williamson**, RN, division director.

The registered nurses became "care coordinators" with duties that included all the functions previously handled by as many as three staff members. These include patient rounds, assessments, utilization review, and discharge planning. In the initial months, the social workers handled their own patients with support from the LPNs who provided utilization review.

The departments were brought together as a team in May 2002.

"We had an opportunity for improvement. The case management department was fairly new at Thomas Hospital. By bringing these departments together, we could enhance communication and coordination of their separate functions," she says.

The initial plan called for cross-training all staff members to handle case management duties, including assessment, rounds, discharge planning, and utilization review.

The model has evolved to a team approach with teams of two RN case managers and one social worker assigned to a group of physicians. Currently, all of the positions are filled by RNs and social workers, Williamson says.

"Nurses and social workers have strengths that are unique to their individual background and experiences. The case management team approach utilizes these strengths to their greatest advantage," she says.

The teams coordinate care for as many as 30 physicians at a time. The RNs divide the physician list and manage the cases, consulting with the social workers to help with difficult discharge planning issues, placements, and financial assistance.

"The teams work together and share duties depending on how much time they have. They pitch in and help each other when one person has a difficult case. If one team is overloaded, we expect the other teams to help," Williamson says.

Thomas Hospital is a 150-bed acute care hospital with a 10-bed skilled unit within the hospital, an emergency department (ED), and a heart surgery program that opened in November 2002.

Williamson is one of four division directors, all of whom make daily rounds as part of the hospital's commitment to customer service, the hospital's No. 1 goal for the past two years.

The administration has set a goal of scoring in the 95th percentile or better on patient satisfaction scores. When she makes rounds, Williamson encourages the patients to send in the customer satisfaction survey and asks them to let her know before they are discharged if there are ways the hospital could improve their experience as patients.

"We believe our case management efforts can support the hospital's overall success with customer service. When we improve patient care, it will ultimately increase patient satisfaction and physician satisfaction," she adds.

The case management team set out to gain physician buy-in from the outset. To help soften the approach and to encourage physicians to embrace the changes, the team decided to call the case managers "care coordinators."

"The primary purpose behind implementing an effective case management program is to improve patient care. Done well, case management can reduce a patient's time in the hospital. It provides a single contact for patients, families, and physicians and identifies the patient's needs early on so the patient and family can make more informed choices and decisions," Williamson adds.

To foster a close working relationship between physicians and care managers, each team is assigned to physicians, rather than by unit or specialty. The care coordinator handles all of the physician's cases. The arrangement means that the physicians don't have three or four different people calling them about cases.

"While excellent patient care has been and will

always be our main focus, developing good working relationships runs a close second. We have tried to bring care coordination on in a physician-friendly way. We hope the physicians see that we are here to help them and help their patients," she adds.

The system seems to be working. When word got out that Thomas Hospital was planning to make additional changes in its care coordination department, one physician made it a point to tell Williamson that he preferred to keep the care coordinator he had been working with because she understood how he practiced. "That same physician had been totally opposed to case management a year before. We had been working really hard to get physician buy-in. Getting support from this physician was a real success for all of us," she says.

Each morning, care coordinators generate a census and identify their patient population for the day. They retrieve physician orders that might need immediate attention and meet with patients and families to identify goals and anticipate discharge needs. The team conducts chart reviews throughout the day for utilization review.

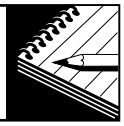
Discharge planning begins on admission, Williamson says. "Although some patients may not require intervention, all cases are reviewed and followed. Some patients may be admitted and discharged without actually being seen or interviewed by a care coordinator."

The redesign process has not been an easy one, she says. The administration made the decision to make all the positions full time, eliminating many part-time positions that existed before the redesign. "Our model continues to evolve as all parties go through a learning process."

The hospital recently added a dedicated care coordinator for the outpatient program and the ED and created a new care coordination position to cover weekends.

"The focus of our case management is on the patient and providing cost-effective, quality health care. As long as we keep this focus, the implementation will be successful," Williamson says. ■

GUEST COLUMN



Learn how to reduce costly staff turnover

By **Patrice Spath**, RHIT
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Forest Grove, OR

In today's tight nursing labor market, case management directors must find ways to keep staff from seeking greener pastures. The cost of hiring and training new employees is significant.

That's why it is important for directors to motivate and retain quality staff whenever possible. Not only is the labor market tight, but budgets are even tighter. However, there are many nonmonetary ways managers can help department staff feel understood and valued. Think about how staff in your department would answer these questions:

- Would you like clear and specific goals so you always know exactly what's expected?
- Would you like to know just how well you're doing?
- Would you like your boss or the medical staff to be aware of the most valuable contributions you've made?
- Would you like to know where you're doing a great job and where you need to shape up a little?
- Would you like a pat on the back when you've done a great job?

Improving the work environment for case managers can cost very little if the manager just cares, communicates, and celebrates accomplishments. Here are some tips for retaining valued employees:

Staff in the case management department need to feel a part of what's going on. Many want to have a say in what work is done and how it will be accomplished. Staff input should be sought when changes are made to their work environment and scheduling. Some may want to be involved in the hiring of new employees. Often, the best employees (and the ones you'd most like to retain) are eager to participate in decisions that affect case management activities. For staff who want to be directly involved in the management of their work, not being given the opportunity may cause them to look for another job that allows more participation.

Whenever possible, provide financial support to those employees interested in continuing their formal education. While some hospitals limit support to what is considered to be job-related courses, it can be important not to be too narrow in providing financial aid. While staff are learning about subjects that are not specifically related to case management, they may be strengthening their self-discipline and self-esteem. The organization can keep

(Continued on page 143)

CRITICAL PATH NETWORK™

Team conferences lower hospital's length of stay

Technology, paper forms increase efficiency

A green monster may not be the first thing you would like to see when you get to work in the morning. But for one rehab hospital, the green monster has been a key to successful implementation of the inpatient prospective payment system (PPS).

At National Rehabilitation Hospital (NRH) in Washington, DC, a bright green pen-and-paper form has taken up residence in each patient room to help team members document the initial functional independence measure score required under PPS. The green form is hard to miss; but if someone neglects to record a score in the required first three days, the hospital's PPS coordinator will make sure it gets done.

ALOS dropped to lowest level in 17 years

"Before PPS, we used to rate the patient as to level of function. With PPS, you have to rate what the burden of care is," says **Rosemary Welch**, RN, MSA, CNA, vice president for patient care services.

"It's very important for all team members to do the ratings. If the patient had one incontinent event in the middle of the night, the day nurse wouldn't know about it. That one event creates a whole list of actions nursing must do — look at medications, clean up, notify the physician. We would have missed that had we only been rating them the old way, which was usually on the day shift. It has made us more aware of what happens to the patients. Obviously, the patients get better care the more we know about them."

NRH also has changed to daily team conferences and has added a nurse coordinator with no patient load to ensure communication and follow-up with nursing staff.

It's working. In the first two months of using the system, NRH's average length of stay (LOS) dropped two days to 18 days, the lowest in the hospital's 17-year history. NRH has maintained that LOS for more than a year. The hospital, which had budgeted for a first-year $1 million loss due to PPS, ended up in the black. But more important, patients are benefiting from a more cohesive, efficient approach to care.

Cathy Ellis, PT, director of physical therapy, occupational therapy, vocational rehab, and therapeutic recreation, says while PPS has its problems, the new system has resulted in positive changes at NRH.

"It has improved our team functioning. The real positive thing has been the way we approached PPS from the perspective of process improvement. The entire team was included in the process, from staff level up to VPs. Our medical director was integrally involved. We didn't fall into a situation of 'we hate PPS.' Instead, we improved our team function," she says.

Redesigned team conference system

The NRH staff are most proud of the redesigned team conference system, which grew out of an intensive benchmarking process.

"Each team member called several facilities they were familiar with, and we did conference calls and a site visit. We looked at best practices, examined data, and pulled in standards from the Commission on Accreditation of Rehabilitation Facilities and the Joint Commission on Accreditation of Healthcare Organizations," Ellis says.

"Our goal was to create a patient-focused model of care that would actually improve the quality of patient care. We knew we wanted a model that was patient-focused, with a highly

integrated team that would allow us to manage our patient care tightly day to day."

Previously, team conferences were held twice weekly for one to 1½ hours. Each patient would get a formal conference once a week. But the meetings were not particularly efficient, and team members were concerned about fragmentation and confusion over such issues as discharge dates, Ellis says. Now, the teams meet daily for half an hour, with two to four patients scheduled for formal conferencing on a rolling basis. The case manager runs the meeting, which begins with a five- to 10-minute discussion on big issues, such as pain management or discharge plans, and moves on to the formal conferencing.

Physicians have easy access to data

One logistical hurdle was setting a time for the meetings that could accommodate the schedules of physicians, nurses, therapists, case managers, social workers, and psychologists. The hospital settled on meetings at 8:30, 9, and 9:30 a.m. and another at 1 p.m. for its various teams.

Because nurses busy delivering patient care often missed the team conferences under the old system, NRH appointed a nurse coordinator with no patient load to attend the meetings. "She serves as the liaison between the team and the nursing staff," Welch says. "Nurses often felt they were out of the loop on the team conferences, but it is so important to have their input. We also get improved action because now there is somebody to actually follow through. The nurse coordinator doesn't have a patient load, so if there's some piece of equipment that needs a rush order or a different dressing needed, she has the ability and the time to get it. It relieves stress for the nurses."

Ellis notes that the nurse coordinator provides cohesiveness to a staff of constantly rotating nurses. "The coordinator position is full-time permanent, and she is at the team conference every day. She communicates regularly with frontline staff nurses who are delivering most of the care to the patient."

The team's case manager runs the meeting, and it falls to that person to prepare reports on the patients ahead of time. The advance preparation, while time-consuming for the case manager, makes the meeting much more fruitful, she says.

The hospital has alleviated some of the burden on the case managers by making their conference report also serve as their weekly progress note for therapy. Because the reporting has already been done, conference time can be used for productive discussion on how to address any issues. "We put the report up on a screen at the front of the room," Ellis says. "Everyone can see the report, whether the patient's goals are being met or not met, any barriers to achieving their goals, and adjustments to the treatment plan."

Paul Rao, PhD, vice president for clinical services at NRH, says another component of the hospital's PPS success has been the change to eRehabData, the web-based outcomes system offered by the American Medical Rehabilitation Providers Association in Washington, DC.

During team conferences, case managers can modify the report on-line and even can interject benchmark data simultaneously.

Another benefit is that physicians have easy access to the data. "We now have physicians every morning looking at how their program is doing. That was never the case before," Rao says. "They used to have to wait three months for the data. Web access has allowed every physician and every manager to see how their patients are doing compared to the nation, how we did over the last three quarters, how we did today. It's a huge change in terms of how our physicians have been analyzing data and managing results."

[For more information, contact:

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Pre-testing patient safety tool helps ensure success

Evaluation helped create clear copy for patients

The University of Washington Medical Center in Seattle is in no hurry to implement a tool an ad hoc committee created to teach patients their role in safety issues. It is running it through a series of pre-tests before implementing it housewide.

Evaluation began with eight patient advisors who were sent the tool and then interviewed on the telephone. It was a good way to identify problems before the committee proceeded with more structured pre-testing of the tool, says **Cezanne Garcia**, MPH, CHES, manager of patient and family education services.

Five of the eight people said that they would feel uncomfortable asking their health care provider to wash his or her hands, so the instructions were changed to prompt the patient to ask everyone to wash their hands.

The advisors also said they liked the sections of the tool that had bulleted information vs. the parts that had narrative instruction. As a result, the committee changed the tool providing bulleted lists in all sections.

On the advice of the reviewers, the title was changed as well. The original title was "Patient Safety: Be Our Partner." The new title is "Partnering with You to Make Health Care Safer." There was some confusion on the exact meaning of patient safety, and that prompted the change.

Once the tool was revamped, the second phase of the testing began. In that phase, 30 patients in the inpatient and outpatient oncology setting were given the tool along with an evaluation form and asked to provide feedback on whether they found the tool useful and easy to understand.

In patient care rooms, the tool and evaluation form was left by the interviewer who returned in about 15 minutes to pick up the evaluation sheet. In the waiting room, the materials were distributed to several patients and then the interviewer simply waited until all had completed the task.

One patient who reviewed the tool wrote, "These are clearly the basics, but they give me a good solid foundation to know what I can do."

Once the tool is fine-tuned, it will be implemented in three inpatient cancer areas and an affiliate.

"We are going to implement it systemwide for a particular patient group. One of the things we want to learn a little bit more about is how we can best prepare our staff who work in these areas for what may be a potentially stronger advocacy voice that patients or family members may present by use of this tool," says Garcia.

Oncology service was selected as the test site because the instructions are aligned with the current practices in this patient care area. Hand washing is a paramount issue with oncology patients as well as infection control, as is careful monitoring of medication.

Once it is clear how best to orient staff to the tool that will be given to patients at admission or in appointment packets, it will be launched housewide, says Garcia. This should take place in three to six months, she says. ■

ABSTRACT & COMMENTARY

Staff education cuts vent pneumonia rate in half

With a cost savings of more than $400,000

Source: Zack JE, et al. **Effect of an education program aimed at reducing the occurrence of ventilator-associated pneumonia.** *Crit Care Med* 2002; 11:2,407-2,412.

Abstract: A focused-education program was associated with a dramatic reduction in the incidence of ventilator-associated pneumonia.

The purpose of this pre- and post-intervention observation study was to evaluate the effect of an educational initiative on ventilator-associated pneumonia (VAP) rate.

The educational program was directed toward respiratory therapists and critical care nurses. The patient population consisted of those developing VAP during a two-year period.

A multidisciplinary task force developed policies and an educational initiative to reduce VAP rates. The educational program consisted of a self-study module, lectures, and pre- and post-testing. The focus of the self-study module was coverage of general topics related to VAP and specific emphasis on risk-reduction strategies.

Successful completion of the program was required of all respiratory therapists and made available to critical care nurses on an elective basis.

Posters related to VAP were posted throughout the ICU. The pre-intervention period occurred from Oct. 1, 1999, to Sept. 30, 2000, and the post-intervention period occurred from Oct. 1, 2000, until Sept. 30, 2001. The diagnostic criteria for VAP were a modification of those established by the American College of Chest Physicians.

A total of 114 respiratory therapists completed the educational program. The average correct exam score increased from 80% to 91% ($P < 0.001$) after completing the educational module, and the average score six months after implementing the intervention was 85%. The educational module also was completed by 146 critical care nurses, and their scores increased from 81% to 91% ($P < 0.001$).

During the 12-month period before the intervention, the VAP rate was 12.6 per 1,000 ventilator days. Following the intervention, the VAP rate was 5.7 per 1,000 ventilator days — a decrease of 57.6% ($P < 0.001$). The cost saving associated with this intervention was calculated to be at least $424,000. Zack and colleagues concluded that an educational program focused on respiratory therapists and critical care nurses resulted in significant reductions in VAP rate.

Commentary by Dean R. Hess, PhD, RRT, assistant professor of anesthesia at Harvard Medical School and assistant director of respiratory care at Massachusetts General Hospital.

Nosocomial infections are an important cause of morbidity and mortality. Pneumonia is the most common nosocomial infection, and 86% of nosocomial pneumonia cases are associated with mechanical ventilation.

Respiratory therapists and intensive care nurses are involved intimately in the care of mechanically ventilated patients and are, thus, uniquely positioned to affect VAP rates. Significant opportunities exist to improve VAP prevention practices.[1-3] These include decreasing the frequency of ventilator circuit changes, increasing the use of noninvasive ventilation, and elevation of the head of the bed.

Despite considerable evidence that has emerged in recent years, approaches to the prevention of VAP remain archaic in many intensive care units.

Although there is considerable evidence of the benefit of the semirecumbent position for the prevention of VAP, I frequently observe mechanically ventilated patients who are not positioned accordingly.

Despite considerable evidence[4] that changing ventilator circuits and in-line suction catheters at regular intervals does *not* decrease VAP rate (and a meta-analysis suggests that this might actually *increase* VAP rate), the practice of changing circuits at regular intervals continues in many hospitals. I know of instances where infection control departments blocked the plans of respiratory care staff to implement the practice of as-needed ventilator circuit changes because adopting such a practice "does not make sense!"

Unfortunately, what makes sense in the minds of some (dare I call this "expert" opinion?) still trumps high-level evidence in many hospitals. Despite evidence that it decreases intubation rate, increases survival, and decreases VAP rate, noninvasive ventilation in appropriately selected patients remains underused in many hospitals.

This study by Zack, et al. shows that an educational intervention directed primarily at respiratory therapists and critical care nurses can significantly reduce ventilator-associated pneumonia rates and associated costs.

However, the researchers have not reported whether this intervention affects other important outcomes such as antibiotic use, length of hospital stay, or mortality. In spite of these limitations, an education program such as the one described in this study should be considered — particularly for hospitals with a higher than expected ventilator-associated pneumonia rate.

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JCAHO hospital standards reduced to 225 from 508

The Joint Commission on Accreditation of Healthcare Organizations has slashed the number of standards in the 2004 hospital accreditation program from 508 to 225 as part of the agency's Shared Visions, New Pathways initiative. Agency officials have said the initiative is intended to streamline standards and focus the Joint Commission survey on operations and systems that directly affect patient safety and quality.

The requirements for 2004 essentially are the same, officials say, but they note that some "elements of performance" that existed in one accreditation manual may now be applicable across all manuals.

In addition, the new format integrates the assessment, care, education, and continuum of care chapters into a single chapter.

Health care personnel may review the new standards, along with a comparison to the current standards, by going to www.jcaho.org and clicking on "2004 Pre-Publication Standards Now Available." ■

AMBULATORY CARE
QUARTERLY

Consider using electronic charts instead of dictation

Save more than $400,000 in transcription costs

Switching to an all-electronic system in the emergency department (ED) for charting and other functions is only a dream for some cash-strapped facilities, but an Ohio hospital is showing that the high initial cost can be recouped quickly through the money saved on transcription and other services. The hospital is saving more than $400,000 a year in transcription costs alone.

Mount Carmel St. Ann's, a community hospital in Westerville, OH, adopted an electronic system July 10, 2001, for physician and nurse documentation, triage, interfaces, and an ED tracking board.

With more than 65,000 annual patient visits for the 40-bed ED, hospital leaders hoped the updated systems would increase efficiency and improve the quality of patient charts, says **Sonja Howard**, RN, DSN, system administrator for the ED computer information system and clinical educator for the ED.

Hospital leaders anticipated the system eventually would pay for itself though improved efficiency, but Howard says they were surprised at how quickly they recouped the investment.

Mount Carmel St. Ann's uses a comprehensive electronic ED system manufactured by A^4 Health Systems in Cary, NC. Many other manufacturers offer similar systems promising the same results.

A spokeswoman for A^4 says the hospital spent about $1 million for the entire system.

That cost is being recouped in about two years almost entirely through the savings in transcription costs, Howard says.

"We were 100% transcription in the past, and we set a goal with the new system that wanted charts to be 80% on the new system and 20% transcription," she says.

"From the beginning, we were at 92% usage of the system, and we've never been below that. It's worked much better than we thought it would."

All of Mount Carmel St. Ann's emergency physicians and about 50 nurses are documenting patient information with the new electronic system. A 92% reduction in dictated charts means the ED no longer has to pay for transcribing about 58,500 charts per year.

At an average cost of $7 per transcription, the ED is saving about $409,500 per year. Two years of those savings almost covered the large start-up costs for the whole system, Howard says.

More savings with less use of paper forms

And those weren't the only savings. Switching to an electronic system helped Mount Carmel St. Ann's eliminate much of the paperwork that is standard in an ED, so there was the added savings of not having to buy the forms.

In the year before adopting the electronic format, Mount Carmel St. Ann's spent $41,200 on forms for the ED. The electronic system cut the need for those forms in half, saving $20,600 each year.

Processing written charts cost an estimated $16,000 per year in staff time, which is eliminated with the new electronic system. That amount went straight to the bottom line. So adding the savings from transcription costs, forms, and processing charts yielded a total savings in the first year of $446,100.

Two years after implementing the system, Mount Carmel St. Ann's had recovered $892,200 of its $1 million investment.

But if you add in other savings for the hospital, the break even point was passed even earlier. Improved charting and documentation led to an increase in gross charge capture per day of about $10,000, yielding a gross increase per year of $360,000.

With a contractual allowance of 50% and a collection rate of 60%, the facility improved charge capture by $1.08 million in the first year. Better

documentation also helped physicians increase their net collections per patient by an average of $20, yielding $1.2 million more reimbursement for ED physicians in the first year.

Howard says the switch to an electronic system was so successful partly because Mount Carmel St. Ann's adopted the entire system at once instead of phasing in the different parts.

After a 10-month installation and training process, more than 140 clinical and nonclinical users in the ED started using the entire electronic system one morning. One day the ED functioned on paper, and the next it was entirely electronic.

"That was painful, but it's the way you need to go to be successful," Howard says. People often want to phase in different portions to make it easier, but you get "stuck" when you do that, she says.

"No matter what you do, there will be difficulties, and that implementation over time gives naysayers the chance to say, 'I don't want to do this. It's not working,'" she says.

Howard also attributes much of the success to the time spent customizing the different screens used for information input.

Some physicians were reluctant to adopt the system at first and cited justifiable concerns that the input screens might restrict the type of data they could put on patient charts and water down the quality of the information.

The biggest hurdle was the history of present illness (HPI). Physicians were concerned that telling the patient's story can be difficult on a screen where you select from a list of options, Howard says.

"But we worked with that concern and built lists that would meet the needs for the top chief complaints like chest pain and abdominal pain," she says.

They customized those enough that the doctors became comfortable using the lists" Howard says.

"If you look at dictated notes, they pretty much say the same thing over and over again," she says. "They may say it a little differently each time, but they follow a pattern, and you can build that pattern into the system."

Supportive physician can smooth transition

Enlist a physician to champion the adoption of such an electronic system, Howard advises. It is normal for physicians to be skeptical of a system in which they won't dictate notes in the style they're used to, she says. A physician champion can be the one who takes the heat from colleagues who aren't as enthusiastic and helps bring them around.

Nurses use the electronic system for triage, and then a physician reviews that information and can agree or amend it. Then the physician uses another screen to enter the HPI, with the system prompting the physician with common questions about the patient's chief complaint.

The next step for the physician is to go to the review of systems, which can be minimal or extensive depending on the severity of the patient's condition.

The system also includes screens for documenting the physician's examination of the patient.

They go through each one of those to build their documentation. "In the old world, they would have dictated all of that," Howard says.

They still have the option of dictating if they think they can't tell the story adequately with the system. "Physicians will still dictate notes for some psychiatric cases and others where they can't get everything they want in the system," she adds. ■

Documentation errors are easy to avoid and correct

Don't obscure errors; include all dates and times

One procedure is finished. The surgeon is ready for the next patient. Turnover time is critical. Everyone moves quickly from one area to the next. What about your documentation?

It's one thing to keep everything moving swiftly throughout the ambulatory surgery process, but don't let the quick pace affect the completeness or accuracy of your documentation, says **Anne M. Roy**, RN, JD, regional operations manager of Health Inventures, a health care consulting firm in Westminster, MA.

"I'm finding that most documentation errors are simply mistakes made when shortcuts are taken to save time," she says.

To ensure that sloppy or inaccurate documentation doesn't cause a problem in patient care or in a liability claim, Roy suggests four areas that require your attention:

- **Use approved abbreviations.**

"Don't make up your own abbreviations," emphasizes Roy. Every outpatient surgery

program should have an approved list of abbreviations for documentation purposes that every nurse can access easily, she suggests.

"If there is no abbreviation listed for the word you want to use, spell it out completely," Roy adds.

- **Date entries.**

"People don't date entries," says Roy. Even if a month and day are used, the year often is left off the entry, she adds.

"It's important to keep the year in the documentation, because legal issues can occur years after the procedure," Roy points out.

Each time the chart moves to another department or another staff member, the entry should have the full date and time on it, she adds.

- **Don't hide errors.**

Don't ever scratch out an entry to the point you can't read what's written, says Roy. "If you make an error, draw a line through the error, then write on the next line," she says. "Make it obvious that you're not trying to obscure something by starting the entry with the phrase 'correction to entry above.'"

When you do draw a line through an entry, be sure to put your initials, as well as the date and time, she adds. Also, ban any type of correction fluid designed to cover up ink, says Roy.

Although errors happen, and you need to correct them, you should never obscure any information, she adds.

- **Insert late entries appropriately.**

"If you forget to enter something and go back to the chart later after other entries have been made, don't try to squeeze the entry between lines of information just so everything will be chronological," says Roy.

"Just start the entry with the phrase 'late entry' and write the information along with the date and time of the entry," she explains.

The latest you ever should add information would be the next business day, Roy adds. After that point, the accuracy of your memory or the information could be called into question, she says.

Also, never sign documentation for someone else, Roy emphasizes. "This doesn't happen often, but I've seen cases of nurses leaving work, then calling back to a friend to ask them to add some information to the chart."

Although it is not a frequent occurrence, Roy says that it is alarming because it can place the second nurse in a precarious position.

"If you do have to add information to a chart for someone else, be sure to start the entry with the statement that you received a call from the nurse who asked you to add the missing information," she suggests.

As more ambulatory programs look at computerized documentation, there are issues to keep in mind.

Computerized documentation can ensure a complete record because the system prompts nurses to add missing information as they chart, she says. Also, there are no legibility problems with a computerized record, Roy adds.

These were among the reasons the outpatient surgery staff at Trinity Medical Center in Moline, IL, switched to computerized documentation when a new same-day surgery facility was opened, says **Patti A. Berens**, RN, nurse manager for Trinity's recovery care unit.

"Not only did the computerized documentation improve accuracy, but having the record on-line also means that the chart is always available," she points out.

The software used by Trinity is manufactured by Meditech in Westwood, MA, and does not delete information if an error is made, Berens says. A notation that an error in documentation was made along with the date and time of the correction as well as the reason for the initial error are entered, she explains.

"I also recommend that only certain people be able to correct documentation entries," Roy says. This gives managers and supervisors an opportunity to double-check information and make sure errors are corrected properly, she adds.

With a computerized record, it is important that every nurse have his or her own identification name, code or number, and password, suggests Berens. "We also tell nurses to be sure to close out the chart completely when they are finished with their documentation so that no one can accidentally document on their patient's record," she adds.

Some electronic medical records allow access and entry by two or more people at the same time, sources warn. That access can result in duplicate entries of data. One entry can override the other, and only one entry is made instead of two, or no entries are filed to the record, sources say.

Another danger of a computerized system is the tendency to include more information in the documentation than is needed, says Roy. "Some computerized forms that I've seen are 50 pages long," she says. "Take a look at the forms you use,

and identify the redundant or unnecessary information to eliminate. Ask your medical records personnel — especially a registered record administrator — as well as your risk management director, to advise you as to the information that is needed," she recommends.

One of the most important facets of accurate documentation is to document as you go, says Roy.

"The only way to make sure another nurse knows exactly what is going on with your patient if you go on break or transfer the patient from the OR to recovery is to write it all down when it happens," she says.

Complete information is especially important with medications related to nausea or pain, Roy adds. "Don't just write down that you gave the patient 50 mg of meperidine. Also, document whether or not the medication worked." This step prevents the following nurse from repeating the same dose and medication if it didn't work the first time, she explains.

Berens points out an extra benefit to computerizing documentation: "Not only is our documentation more accurate, but our patients appreciate the fact that they don't have to keep repeating information as they move through the same-day surgery program," she says.

"With the information on-line and readily available to each department, staff members can just verify the information instead of asking patients to repeat it for their records," Berens explains. ■

COST-SAVING TIP

Save money with *Price is Right* contest

Do you ever see nurses in your emergency department (ED) misusing or wasting supplies, and wish they knew what these items actually cost? Here's a solution: Ask nurses to guess what the ED pays for various common items, suggests **Patricia Carroll**, RN,BC, CEN, MS, former ED nurse at Manchester (CT) Memorial Hospital and founder of Educational Medical Consultants, a Meriden, CT-based consulting company specializing in educational programs for health care professionals.

A *Price is Right* contest was held at Carroll's former ED, with 10 products set up in a conference room for 24 hours so that every nurse had a chance to participate. "Night shifts usually get excluded from these things," she notes.

ED nurses were given sheets with each item listed and asked to guess the price of each item.

"To avoid confusion, this corresponds to a display set out on tabletops, so that the nurses can see exactly what the items are," she says.

The nurse who guessed closest to correct won a prize, such as a pass for free meals in the cafeteria or a credit at the hospital gift shop, Carroll says.

The contest put an end to an expensive habit that ED nurses had, says Carroll. "The problem was that it took a while for us to get a chart when a patient was very ill and rushed in by EMS," she says.

Nurses tended to grab individually wrapped 4 x 4 gauze pads to write on at the bedside, says Carroll.

"We could write on the wrappers, and they were big enough," she says. "Once nurses learned how expensive these items were, no one used them as handy note paper again."

Instead, ED nurses carried notepads or used very inexpensive paper towels for emergency charting instead, says Carroll. For your ED's contest, do some research to find out what your department's "budget-busters" are, she says.

Your ED's budget-busters might be products that are being used improperly; items that are easily broken if they are not handled with care, such as hand-held monitors or pulse oximetry sensors; nondisposable items that end up in the laundry or trash because people are careless when cleaning up; or items that are handy to have at home, such as surgical adhesive, Carroll suggests.

"The bottom line is that most nurses don't have a clue what things cost, and therefore, don't think twice about it," she says.

"Once their eyes are opened, they realize that if money is going to replace equipment and buy twice the number the supplies that should be needed, that's money that is not available for salaries — either raises, or additional staff positions," Carroll adds.

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(Continued from page 134)

the loyalty of employees by supporting the achievement of their career goals.

Like everyone, case managers want to be appreciated for their work. Unfortunately, members of the health care team only seem to notice case managers' work when they do something exceptionally good or extremely bad. Some of the most valuable employees are those who come in every day, don't bother anyone, and get their work done in a reliable, routine way. These staff can be depended on to be productive and efficient, yet they often are overlooked when the thanks are handed out. Every once in a while, take time out to thank those who are not the usual recipients of appreciation. By showing some gratitude for the routine work done by people in the case management department, job satisfaction will go up.

Good employees want to know specifically how they are doing and how they can improve. Often, the performance appraisal instruments used in hospitals contain only generalized feedback and numeric evaluations. During the employee's performance evaluation, be sure to discuss specific examples to illustrate what you like or dislike about what the person does. Everyone working in the case management department should understand what tasks are to be done and how they are to be accomplished.

Excellent employees often can become frustrated by nonsensical rules, regulations, and procedures. Not much can be done to change the requirements imposed by external agencies; however, a lot could be done to simplify things internally by taking a good look at the case management department's policies and procedures.

Look for anything that might call for extra paperwork, unnecessary steps, superfluous approvals, or similar nuisances. Where can you slash red tape, eliminate burdensome bureaucracy, or remove clutter? Eliminate anything that may be an obstacle to the effective and efficient operation of case management services. Do whatever possible to make it easier for case managers to get things done.

It's important that people have the tools they need to get their jobs done. Waiting in line to send a fax can decrease efficiency and build staff dissatisfaction. Not having necessary resources can cost time and cause turnover. Good employees want to do a good job. Communicate job expectations and give them what they need to achieve peak performance, and case managers will get the results the hospital wants. Make their work more difficult, and you soon may be replacing them.

Case managers have serious job responsibilities, but that doesn't mean they have to take themselves too seriously. With the lean staffing in most departments, everyone has a significant

CE *questions*

9. The case management staff at Northeast Medical Center in Concord, NC, concurrently reviews approximately what percentage of Medicare patients?
   A. 70%
   B. 80%
   C. 90%
   D. 100%

10. To alleviate the problem of "social admissions," Northeast Medical Center made arrangements with what type of facility to admit patients directly from the emergency department?
   A. assisted-living facilities
   B. skilled nursing facilities
   C. home health agencies
   D. all of the above

11. Each case management team at Thomas Hospital in Fairhope, AL, is assigned to:
   A. units
   B. specialties
   C. physicians
   D. none of the above

12. According to Patrice Spath, RHIT, an exit interview should be conducted within a week of the employee leaving the organization.
   A. true
   B. false

Answer Key: 9. C; 10. A; 11. C; 12. B

COMING IN FUTURE MONTHS

- Measuring and communicating the success of your case management efforts
- Skills and tools for the effective case management director
- Dealing with frequent-flyer patients
- Special report: The challenges of discharge planning for illegal immigrants

amount of important work to do. However, employees also should have fun while they work. Celebrate birthdays, promotions, and special events with short parties. The celebrations do not have to be long; just a short period of fun together can go a long way to adding humor in the workplace.

Don't think that once employees turn in a resignation, all is lost. Managers overlook an important tool for discovering what keeps employees happy: the exit interview. By interviewing departing employees, the director can discover key information regarding satisfaction with position, working environment, pay, benefits, co-workers, etc. — information that can be used to help prevent other staff from leaving the department. Ask departing employees to fill out a pre-interview form as a springboard to a more productive exit interview. The answers won't tell the whole story, but they will be useful for preparing specific follow-up questions for the exit interview. The form should cover basic questions like these:

- What are the primary reasons you decided to leave your position?
- What did you like most about your job? Least?
- How did you feel about working with other employees in the department?
- In what way did this job fail to meet your career objectives?
- What would you have done differently if you'd been the manager?
- How would you evaluate your performance?
- What part of dealing with other people did you find most frustrating?
- How would you rate your pay and benefits?
- How would you rate the training you received?
- If you could have made any job changes, what would they have been?
- Do you feel you were given ample opportunities for advancement?
- How would you rate your overall working conditions?

During the interview, it's important to make departing employees feel comfortable enough to answer your questions openly and honestly. Do this by telling them how much you regret losing them.

Also, be sure to tell employees what the interview is meant to accomplish: You want to find ways in which the department can improve. At times, conducting the exit interview while the employee still is on the payroll limits the productiveness of the discussions.

To solve this problem, try waiting until one or two months after employees leave before conducting the interview. This way, they may find it easier to be honest.

Remember, no amount of exit interviewing will make things better for those people still working in the department unless the issues raised are investigated and acted on. Share your findings with the appropriate people and make changes to policies or processes when necessary.

Understanding why people leave can be an important step toward reducing turnover in the case management department. ■

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. ■