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HOSPITAL CASE MANAGEMENT™

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

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Inflating LOS for transfer rule DRGs could lead to federal fraud charges

HCFA's transfer payment policy takes a bite out of hospitals' bottom line

One year after the Health Care Financing Administration (HCFA) implemented its controversial transfer payment policy, some hospitals are compensating for lost revenues by inflating lengths of stay for the 10 affected diagnosis-related groups (DRGs).

Those hospitals are walking a fine line between good business practice and what federal investigators might construe as outright fraud against the Medicare system, says **Deborah Hale**, president of Administrative Consultant Services in Shawnee, OK. "When HCFA changed the transfer definition, it said that it would monitor hospitals' response to this ruling," she says. "My interpretation is, if you deliberately start holding your patients longer to capture the full DRG — if you change your practice for financial reasons — then that might be considered an inappropriate practice." **(See related story on DRG 014 fraud probe, p. 151.)**

Until Oct. 1, 1998, a discharge from a prospective payment system (PPS) hospital was always paid at the full DRG rate unless the patient was transferred to another PPS hospital. Under the new rule, which affects 10 specific DRGs, HCFA pays hospitals "transfer payments" rather than full DRG payments for patients discharged to postacute care more than a day earlier than a national "geometric mean" length of stay defined by HCFA.

This means that hospitals with lengths of stay significantly lower than HCFA's geometric mean are penalized with lower reimbursement than that received by hospitals with longer lengths of stay.

In a financial impact analysis completed before the rule took effect last year, the Congressional Budget Office estimated that the transfer payment policy would create overall hospital losses of around $100 million per year. Estimates from the American Hospital Association in Chicago range from $410 million to $450 million per year.

When it instituted the policy, the government claimed that the transfer payment rules were established to prevent the illegal practice of "double-dipping," which HCFA defines as "submitting duplicate payments for care provided during a patient's episode of care." **(See "Breaking the**

KEY POINTS

- A year after the Health Care Financing Administration implemented its controversial transfer payment policy, some hospitals are keeping patients in the hospital longer than necessary in order to receive full DRG payments. That's a risky strategy, say some experts, who warn that inflating length of stay (LOS) solely for financial reasons could provoke a federal fraud investigation.
- At St. John's Medical Center in Tulsa, OK, case managers haven't attempted to increase LOS in response to the new transfer rule, but they have put the brakes on any additional cuts in LOS for patients in the 10 affected DRGs. Meanwhile, at Elkhart (IN) General Hospital, case managers have made no adjustments, despite losing as much as $200,000 as a result of the transfer rule.
- Deborah Hale, president of Administrative Consultant Services in Shawnee, OK, suggests that the best approach for case managers eager to offset losses in reimbursement due to the transfer payment policy is to save money by focusing on patients with complicated conditions who traditionally have had longer-than-average lengths of stay.

chain: How new Medicare changes threaten continuum of care," in *Hospital Case Management*, October 1998, p. 189.)

But some experts have interpreted the new rule as simply an attempt by HCFA to reduce the level of Medicare reimbursement being paid out for the 10 DRGs in question. "HCFA would rather pay a lesser amount to a skilled nursing facility than the per diem rate for the DRG," Hale says. "They would prefer to let hospital practice stay the way it is, with lengths of stay shorter than the geometric means, and pay the lesser amount." That's why increasing LOS to achieve full DRG payment could be a risky proposition for hospitals.

But the potential dangers haven't dissuaded everyone, Hale says. "I am aware of some hospitals deliberately holding their patients in these 10 DRGs longer than they did in the past," she says. "I know of one that miscalculated and is holding patients even two days longer than it would have to [to achieve the full DRG]. Others have determined that they will keep patients until they stay one day less than the geometric mean so they can capture the full DRG. I think that's a risky decision."

At St. John's Medical Center in Tulsa, OK, case managers aren't keeping patients longer as a result of the transfer rule, but reducing LOS for the 10 affected DRGs hasn't been a high priority, either, says **Joyce George**, RN, director of medical information management at St. John's. "We definitely haven't tried to push those patients hard," she says. "Some probably could have been transferred earlier, but I wouldn't transfer them because of the new rule."

In general, the transfer rule hasn't hit St. John's too hard, largely because lengths of stay there were never particularly low for the DRGs in question. "A lot of hospitals were transferring their total joint patients at three days," George says. "We had really not gotten to that point. Our numbers were close to the geometric mean," George says. "Our goal became to make sure that we kept them to the geometric mean more or less, rather than shortening the length of stay. Because they already kind of fell in line, it wasn't that much of a big deal. We just talked to the medical staff about it, told them why the rules were there and why we were doing what we were doing."

One reason the transfer rule hasn't posed much of a problem at St. John's is that for many of the affected DRGs, discharge planners have

10 DRGs affected by HCFA's transfer payment policy

014 — Specific cerebrovascular disorders except transient ischemic attack (medical)
113 — Amputation for circulatory system disorders excluding upper limb and toe (surgical)
209 — Major joint limb reattachment procedures of lower extremity (surgical)
210 — Hip and femur procedures except major joint age>17 with CC (surgical)
211 — Hip and femur procedures except major joint age>17 without CC (surgical)
236 — Fractures of hip and pelvis (medical)
263 — Skin graft and/or debridement for skin ulcer or cellulitis with CC (surgical)
264 — Skin graft and/or debridement for skin ulcer or cellulitis without CC (surgical)
429 — Organic disturbances and mental retardation (medical)
483 — Tracheostomy except for face, mouth, and neck diagnoses (surgical)

OIG uncovers upcoding for stroke patients

A small number of hospitals, just 35 out of 4,883, had abnormally high DRG 014 discharges compared to national figures, according to a report just released by the Health and Human Services (HHS) Office of Inspector General (OIG). The OIG examined the proportion of DRG 014 discharges to total discharges in 1996 and the increase in the proportion of DRG 014 discharges to total discharges between 1993 and 1996.

The investigation showed that 4% of DRG 014 discharges sampled should have been coded to a lower-weighted DRG, according to the OIG. The Health Care Financing Administration (HCFA) pegged the overpayments at $11.9 million, or $1,716 a head.

In 1996, Medicare reimbursed hospitals almost $1.9 billion for DRG 014, a code used for stroke patients that can trigger a higher Medicare reimbursement than other codes where patients may exhibit similar symptoms. Among those 35 hospitals, DRG 014 discharges increased 73% (from 2,281 in 1993 to 3,941 in 1996), while DRG 014 discharges increased only 6% nationwide (from 360,354 in 1993 to 382,130 in 1996). Likewise, the proportion of DRG 014 discharges to all discharges for the 35 hospitals jumped 57% from between 1993 and 1996, while the national proportion increased only 1% during that time.

The OIG referred the 35 hospitals to its Office of Investigations. The report is the latest example of collaboration between HCFA and the OIG to perform routine monitoring and analysis of hospital billing and clinical data to uncover patterns of upcoding. ■

had difficulty discharging patients as quickly as they would like. "We try to get these patients into the level of care that's appropriate for them, but sometimes those beds are just not available, so we have to leave them in acute care. We've never been really tight on those DRGs."

For other hospitals, the transfer payment policy has complicated the discharge planning process, especially when nursing homes aren't on the same page as the hospital, Hale says. Indeed, some case managers have transferred patients to nursing homes as intermediate care patients, only to find later that the nursing home admitted the patient to a skilled bed. "The hospital didn't know about it, and, consequently, they billed their discharge to intermediate care rather than skilled care, which is subject to the transfer definition." Such costly mix-ups have been "the biggest hassle" for many hospitals in dealing with the transfer rule, Hale says.

While patient placement hasn't been a big problem at Elkhart (IN) General Hospital, the transfer payment policy has had some impact on the hospital's bottom line, says **Shelby Morse**, RN, hospital director of case management at Elkhart. "Our finance department has analyzed some of the numbers, and it looks to be between $150,000 and $200,000 in lost revenue," with most of the losses due to DRG 209 (major joint limb reattachment procedures of lower extremity, or total joint replacement), she says.

Even so, case managers at Elkhart haven't made any adjustments to compensate for the lost revenue. Indeed, lengths of stay for DRG 014 (specific cerebrovascular disorders except transient ischemic attack) have actually fallen by almost half a day since the transfer rule took effect. "Most of our stroke patients are going to inpatient rehabilitation here, so there's still revenue," Morse says. "Even though we're getting a smaller DRG payment, we're still getting revenue. We're not hanging around waiting and prolonging patients' overall length of stay just to get one more day of DRG payment."

Good PR offsets financial losses

Similarly, although the hospital has lost money with regard to DRG 209, no changes have been made to Elkhart's popular and successful total joint replacement program. "There's a lot of positive public recognition of that program, as well as positive patient impact," Morse says. "We're not going to change that, because we're getting good PR from it. So even though there is some bottom-line impact, at this point it's not affected us enough for us to really rethink the way we're doing things." That could change, however, if HCFA decides to expand the number of DRGs included under the transfer rule, Morse notes.

Similarly, case managers at the University of Pennsylvania Medical Center in Philadelphia

decided to make no adjustments regarding the transfer payment policy, despite lost revenue. "We have clinical pathways in which length of stay is shorter than the transfer rules' length of stay," says **Maryellen Reilly**, MS, MT, director of clinical resource management and social work at the medical center. "But we felt that what we were doing was best practice, so we stayed with it, even though we knew it would impact reimbursement."

Hale suggests that the best approach for case managers eager to offset reimbursement losses due to the transfer payment policy is to focus their energy on reducing costs and lengths of stay for patients with complicated conditions. "Really focus on the complex patients who stay in the hospital eight, 10, or 12 days, and generate cost savings there rather than trying to save one day here or there for everyone else," she says.

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Hospital cuts length of stay for vent patients by 34%

Average vent duration drops from 4.7 days to 2.9

An innovative set of ventilator protocols has helped case managers at Nash General Hospital in Rocky Mount, NC, cut length of stay (LOS) for ventilator patients by 34% and overall LOS in the intensive care unit by one-fourth.

The average duration of mechanical ventilation dropped 38% (4.7 days vs. 2.9 days), and ventilator patients averaged savings of $35,000 in hospital charges. During the first nine months of implementing the ventilator protocols, the intensive care unit reported no cases of ventilator-associated pneumonia, down from a previous average of 12.9 infections per 1,000 ventilator days. **(See pp. 153-154 for a sample protocol and pathway.)**

KEY POINTS

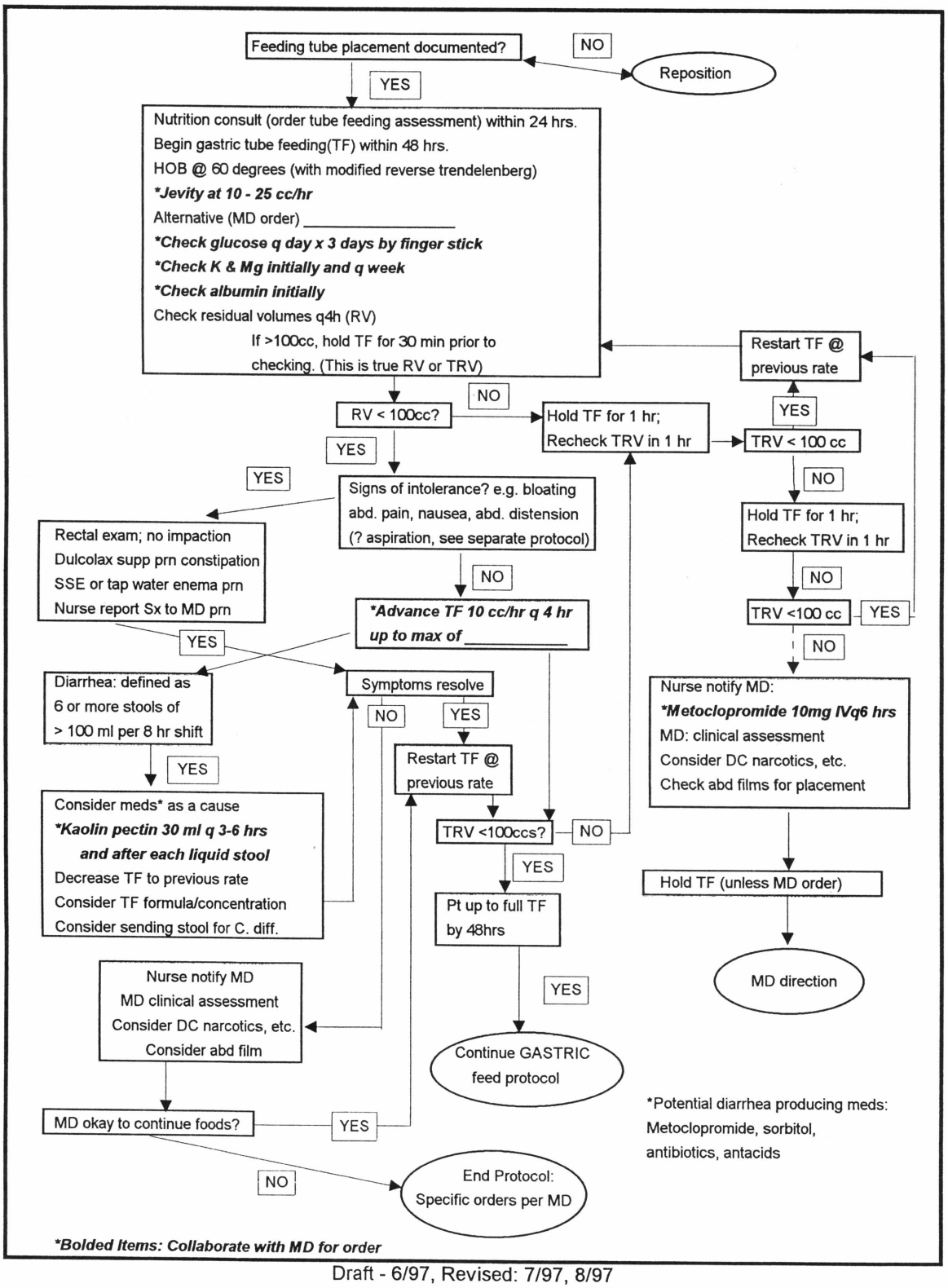
- By implementing an innovative set of ventilator protocols, case managers at Nash General Hospital in Rocky Mount, NC, have cut length of stay for ventilator patients by 34%, reduced the average duration of mechanical ventilation by 38%, and saved the hospital an average of $35,000 in charges per ventilator patient.
- Elements of the protocol include using pulse oximetry in place of autologous blood gases when possible, performing a chest X-ray and initiating tube feeding immediately after the patient is placed on the ventilator, taking sputum cultures to determine a baseline for organism growth and the need for antibiotics, and weaning the patient at certain oxygen levels.
- Ventilator collaborative team members are also examining the possibility of adding a kinetic therapy element to the protocols.

The protocols' success is due in large part to enthusiastic physician support, says **Pam Johnson**, BSN, RN, CCRN, clinical educator for critical care services. An internist / pulmonologist served as the initial physician champion for the protocol project. "With all the changes we made in implementing the protocols in incremental steps, he was the one who would initiate those changes first with his patients," Johnson says. "That was how we got our benchmark data out to the other physicians. They saw how well his patients were doing, how quickly they were weaning [from ventilators], and the decrease in the cost of care for his patients compared to theirs, and that's how we won physician support."

At that time, in 1996, most physicians at Nash used a standard order set in dealing with ventilator patients. While the order sets were useful, members of the ventilator collaborative team believed they didn't go far enough in standardizing care or addressing unnecessary costs. They

(Continued on page 155)

NASH GENERAL HOSPITAL
VENTILATOR COLLABORATIVE
GASTRIC FEED PROTOCOL



Draft - 6/97, Revised: 7/97, 8/97

Source: Nash General Hospital, Rocky Mount, NC.

NASH GENERAL HOSPITAL
VENTILATOR PATHWAY

Draft Two **January 1997**

DAY/DATE ____/____	PHASE 1: FAST TRACK INTUBATION TO FIRST 24 HOURS	PHASE 2A: > 24, < 72 Hours SHORT TERM RESPIRATORY SUPPORT	PHASE 2B: > 72 Hours LONG TERM RESPIRATORY SUPPORT	PHASE 3 WEANING TO EXTUBATION	PHASE 4 POST EXTUBATION TO DISCHARGE
Location Consults	ICU/CCU Notify Pastoral Care Patient/Family Services referral on admission	ICU/CCU ✓ for PT/OT Consult	ICU/CCU ✓for pulmonary consult Review/revise D/C plan with Patient/Family Services Consider transfer to vent facility patient with severely compromised pulmonary function and/or predicted failure to wean	ICU/CCU Consider transfer to PCU-S a physiologically stable patient with failure to wean (Collaborate with MD, RT, PCU-S staff, PFS) Review/revise D/C plan with Patient/Family Services	PCU-S/General Floor Communicate with staff of receiving unit for post critical care needs
Assessment	Initiate Fast Track Weaning Protocol Determine code status Assess for weaning tolerance Q shift and PRN	Assess for readiness to wean Q shift and PRN	Assess for readiness to wean Q shift and PRN Initiate Collaborative Vent Weaning Protocol if weaning criteria are met Assess need for trach at 14 to 21 days	Assess for weaning tolerance Q shift and PRN Continues to meet Weaning Criteria Meets Extubation Criteria - Order to extubate	Transferred stable/off vent, or to vent step down unit, or discharged to another vent facility with uninterrupted care Review unanticipated ICU/CCU readmission within 48 hours
Nutrition	Nutritional Assessment on admission	Collaborate with MD for Nutritional Needs/Nutritional Protocol	Initiate or continue Nutritional Protocol	Continue Nutritional Protocol	Re-establish diet as tolerated/indicated
Vent Management and Meds	Initiate Collaborative Vent Protocol	Continue Collaborative Vent Protocol Initiate Sedation Protocol Initiate Collaborative Vent Weaning Protocol if weaning criteria are met	Continue Collaborative Vent Protocol Initiate Collaborative Vent Weaning Protocol if weaning criteria are met Re-evaluate effectiveness of Sedation Protocol in managing pain or sedation	Initiate or continue Collaborative Vent Weaning Protocol Re-evaluate for discontinuance or selective use of analgesics or sedatives during weaning via Sedation Protocol	Evaluate patient for pain management, collaborating PRN with MD for selective use of analgesics
Diagnostics	ABG's on initiation of mechanical ventilation CXR on intubation or reposition of ET tube	ABG's Q day for the first 72 hours CXR on re-intubation or reposition of ET tube	ABG's PRN to verify oxygenation or ventilation status if SpO2, heart rate, or respiratory rate vary from baseline for longer than 20 minutes CXR on re-intubation or reposition of ET tube	ABG's PRN to verify oxygenation or ventilation status if SpO2, heart rate, or respiratory rate vary from baseline for longer than 20 minutes	
Family	Initiate supportive communications with patient/family. Identify family spokes-person Vent Brochure to family Schedule care conference for day 2 or 3 (Notify MD, PFS, RT, Family)	Maintain supportive communications with patient/family Hold first care conference Schedule second family conference PRN one week after first	Maintain supportive communications with patient/family Hold second family conference Schedule third family conference PRN Hold third family conference	Maintain supportive communications with patient/family Hold patient/family conference/updates PRN	Hold patient/family conference/update to prepare for transfer to post critical care or to finalize discharge plans
Treatments			Initiate PT	Continue PT	
Activity		Initiate Activity Protocol	Re-evaluate Activity Protocol	Re-eval Activity Protocol	

Source: Nash General Hospital, Rocky Mount, NC.

(Continued from page 152)

also provided little flexibility to the bedside nurses and respiratory therapists in initiating the weaning process, Johnson says.

The first major difference between the existing order sets and the new protocols had to do with the number of autologous blood gases (ABGs) performed to check a patient's breathing status after ventilator changes are made. "With the new protocol sets, we limited the ABGs to once a day and any time a change in the patient's status warranted it," Johnson says. Previously, an ABG was performed each time a ventilator change was made, an expensive trend given that ABGs cost about $100 each to perform. "If you're trying to wean a patient and you're checking three or four times per day, the cost is driven up," she says. When possible, nurses use pulse oximetry instead, which costs less and is less invasive for patients.

Other elements of the ventilator protocols include:

- Initiating tube feeding immediately after the patient is placed on the ventilator, pending a physician's approval. Before, patients may have gone a day or two before they were fed.
- Giving drugs for sedation if the patient becomes restless.
- Performing chest X-ray right after a patient is placed on a ventilator to make sure the tubing is in place.
- Taking sputum cultures to determine a baseline for organism growth and the need for antibiotics.
- Weaning the patient at certain oxygen levels.

Patient readiness to leave ICU rated

Another helpful aspect of the protocols has been the implementation of a daily rating system for ICU patients that helps determine when patients need to be moved out of ICU, Wells says. An "A" rating means the patient is on a ventilator or drips and needs to stay in the ICU. A "C" rating means the patient is off the ventilator and drips, is stable, and is ready to move to a regular floor. A "B" rating means the patient is at a point in between and should stay in the ICU until becoming stable.

The ventilator protocol project began with a goal to decrease the average number of ventilator days by 25%, decrease the costs associated with providing mechanical ventilation by 25%, and decrease the incidence of ventilator-associated pneumonia in the ICU — all of which the hospital accomplished within nine months of implementation. The protocols themselves, however, were implemented in incremental stages, beginning with a respiratory-driven protocol designed to wean ventilator patients from mechanically supplied oxygen.

The second stage involved the reduction of ABGs in favor of pulse oximetry. A by-product of this stage was the reduced incidence of nosocomial pneumonia among the ventilator patients.

"We then started looking at the nutritional aspects of our patients," Johnson says. A protocol was developed in which parenteral nutrition was started within 24 to 48 hours. "That way, when the physicians ordered the vent protocols, we were able to initiate the tube feedings at that point," she says.

The final step was to standardize medications used to promote tolerance of the ventilator, including sedatives and analgesic agents. "Before, physicians would use whatever medications [they wanted]," Johnson says.

A standard set of ventilator orders is included in every patient's chart, and the ventilator protocol is posted in the unit. Johnson says the standardization improves patient care and makes staff education much easier. "Before, the nurses and therapists had to work with 30 different physicians with 30 different ways to wean," she says. "Now there's less stress for the staff, and it's easier for them to learn."

Johnson goes over the protocol with nurses during new staff orientation, touches on the topic in monthly inservices for existing staff, and discusses treatment options during daily rounds. She also participates in interdisciplinary rounds twice a week. Physicians receive a manual with the protocols, and the nurses constantly remind them to think about weaning patients.

"We continuously monitor the protocols to make sure that we're still on track with the data," Johnson says. "We have had a lot of turnover with respiratory staff and nursing staff, so we began to see some of the gains we had made in the management of ventilator patients decline. We re-examined that and went back to re-educate new staff and new therapists to get them back up to speed." As a result, Johnson says, the numbers are gradually moving back in line with expectations.

Meanwhile, the ventilator protocols continue to evolve. "We're planning to revisit the issue of

nutrition in the vent patients and fine-tune that process a little more," Johnson says. "We're also looking at the implementation of kinetic therapy for the patients."

For more information, contact Pam Johnson, BSN, RN, CCRN, clinical educator for critical care services, Nash General Hospital, 2460 Curtis Ellis Drive, Rocky Mount, NC 27804. Telephone: (252) 443-8723. ■

New association formed for hospital case managers

Services include job listings, peer mentoring

A national board of directors consisting of case management professionals is establishing the first case management association specifically designed to address the needs and concerns of hospital and health system-based case managers.

Called the American Case Management Association (ACMA), the new organization was formed in an attempt to meet the professional development and networking needs of acute care case managers, says **L. Greg Cunningham**, president of ACMA. Cunningham notes that in the course of his consulting work in hospitals and health systems, many case managers have commented on the relative lack of professional resources available to them. "Other than American Health Consultants' *Hospital Case Management* publication, directors of case management have very limited tools," he says. "There are [associations] that have broad-based offerings, but there is no affiliation that just focuses on hospital and health system-based case managers," he says.

The formation of ACMA also was motivated by the desire to foster closer cooperation between nurses and social workers, Cunningham says. "Many of the individuals in leadership positions around the country who hold professional backgrounds in nursing and social work felt the need to have a forum where the two could work in collaboration for the advancement of case management," he says. ACMA has made a commitment to this collaboration. ACMA's mission statement says ACMA is "the association that offers solutions to support the evolving collaborative practice of hospital / health system case management."

Marcia Colone, PhD, LCSW, director of case management at Northwestern Memorial Hospital in Chicago and a member of ACMA's board of directors, says ACMA is "a critically needed organization that truly integrates the disciplines of nursing and social work. From a case management director's perspective, ACMA's mission for collaborative practice offers a professional bridge that allows us to learn and succeed collectively."

ACMA also has ensured that its board and officers have equal representation from the nursing and social work professions. ACMA's board elected Cunningham, whose professional background is hospital administration and not nursing or social work, to be its first president. Following Cunningham's term, ACMA's president will have a professional rotation between nursing and social work.

The board already has received accolades of support and is forming a national network of ACMA state ambassadors, 50 nurses and 50 social workers representing each state, to be the foundation for the association. The ACMA board has begun developing an aggressive agenda for 2000 and has received requests from various constituents regarding certification, salary / compensation, skill set / competencies, and organization tools and systems.

(Continued on page 165)

KEY POINTS

- A national board of case management professionals has established the Little Rock, AR-based American Case Management Association (ACMA), the first case management association specifically designed to address the needs and concerns of hospital and health system-based case managers.
- The formation of ACMA was motivated in part by the desire to foster closer cooperation between nurses and social workers in the acute care setting. The association's board and officers have equal representation from the nursing and social work professions.
- Members of ACMA will be able to take advantage of the following services: a job opportunities network, an information resource center, a director's forum, and a mentoring service. Annual membership dues are $135.

CRITICAL PATH NETWORK™

Developing an acute cardiac evaluation unit for MI patients

By **Patty Calver**, RN, BSN
Margaret Rider, RN
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Harborview Medical Center
Seattle

Harborview Medical Center (HMC) in Seattle began looking at alternate methods of chest pain evaluation in 1996. This was in response to the need to standardize the rule-out protocol and to provide more efficient care to those patients entering the hospital with atypical chest pain and non-diagnostic ECG changes.

HMC is a teaching hospital staffed with cardiology attendings, cardiology fellows, and residents. Based on each practitioner's previous experience, a series of several different laboratory tests and follow-up studies were ordered. This resulted in laboratory testing requiring anywhere from six hours to 24 hours to rule a patient out for a myocardial infarction (MI).

The admitting resident team admitted medical intensive care unit patients in addition to the cardiology patients. Critically ill patients received early rounds and the less acute rule-out (R/O) MI patients received late afternoon rounds. The late afternoon rounds prevented timely follow-up testing and discharges of the R/O MI patient population.

A group of caregivers led by one of the attending cardiologists developed the idea of an acute cardiac evaluation unit (ACE-U) devoted to the efficient and quality care of the R/O MI patient. Involved in the planning of this new unit were the medical director for the acute cardiac evaluation unit, the associate director of critical care, and nurse managers and staff nurses from the coronary intensive care unit (CICU), emergency department, and medicine/telemetry floor. Also involved were the nuclear medicine medical director and technologists, the project manager for clinical pathways, the medicine clinical nurse specialist, and representatives from nutrition, laboratory medicine, social work, and physical therapy. This group reviewed the current R/O MI/uncomplicated MI pathway and divided this pathway into two separate pathways: R/O MI and uncomplicated MI. The group then revised the R/O MI pathway to more efficiently reflect the needed care for this patient population. **(See pages from R/O MI pathway, pp. 156-158.)**

Revisions made based on trial

While construction of the ACE-U was in progress, the pathway was trialed in the CICU and Medicine/Telemetry floor with patients meeting pathway criteria. Based on the trial, further revisions were made.

The ACE-U opened as a four-bed open-bay unit with an attached room holding a single-head Spect Scan Nuclear Medicine Camera. Central to the unit is a nurses station with central telemetry monitoring for the ACE-U and other telemetry areas within the hospital. One CICU critical care nurse per shift staffs this unit. On the day and evening shift, a medical assistant assists with the care. The average daily census is slightly greater than two. Most admits occur between 1300 and 1700, and most discharges occur between 1100 and 1700.

Once the ACE-U opened, several issues arose. Discussions at staff meetings and informal problem-solving sessions occurred regularly. Problems

(Continued on page 160)

Acute Cardiac Evaluation Unit/Rule Out MI Clincal Pathway Orders:
ADMIT TO ACE-U / 3E-TELEMETRY (Circle One)
MD: PLEASE DELETE ORDERS WHICH ARE N/A, CIRCLE, CHECK BOXES, OR FILL IN WHERE APPLICABLE

Allergies:

Diagnosis: ☐ CP, R/O MI ☐ Syncope ☐ Arrhythmia ☐ CHF ☐ Other _____

Routine Care:
☑ VS (T, HR, R, BP) on admission, advancing as stable to q4 hours
☑ Cardiac Monitoring
☑ Contact HO for: SBP > _____< _____
DBP > _____< _____
HR > _____< _____
RR > _____< _____
T > _____

Please Note: ☑ means standard clinical pathway order. If not indicated, draw a single line through item.

Diagnostic Tests
☑ 12 lead ECG, PT/PTT, CBC, M-7, and 12 lead ECG in AM
☐ AM fasting lipid profile
☑ O_2 saturation monitoring prn
☐ ***If patient meets ACE-U criteria***:
CK - MB and myoglobin (early chest pain panel) in ED = O°, at 3°, and 6° and
SPECT imaging scan within 2° of Tc-99 injection
☐ ***Non ACE-U patients/other rule out MI labs***: specify three tests (late chest pain panel=CK-MB and Troponin I)
☐ early chest pain panel at ____hrs ☐ early chest pain panel at _____ hrs ☐ early chest pain panel at ____ hrs
☐ late chest pain panel at _____hrs ☐ late chest pain panel at _____ hrs ☐ late chest pain panel at _____hrs
or_____

Respiratory Care:
O_2 at _____L/min per nasal cannula to maintain $SaO_2 \geq 92\%$ for 12 hours. D/C O_2 at _____.

Fluids:
☑ IV saline lock (flush q 8° and prn)
☑ Weight on admission and q day
☑ Intake and Output q shift

Diet:
☑ NPO except medications until nuclear scan for ACE-U patients; then AHA diet
☑ Hold caffeine and decaffeinated coffee

Activity:
☑ May have BR privileges as tolerated

Medications:
PRN:
☐ MOM 30 ml PO qd PRN constipation
☐ Prochlorperazine (Cornpazine) 25 mg PR q 12 hours PRN nausea/vomiting or 5-10mg IV PRN q 6 hrs.
☐ Acetaminophen (Tylenol) 650mg PO q 4-6 hours PRN minor non-cardiac pain.
☐ Triazolam (Halcion) 0.125 mg PO q HS PRN sleep, may repeat once.
☐ Versed 1-3 mg IV PRN while at nuclear medicine scan

Chest Pain:
☐ Nitroglycerin 0.4mg SL (hold if BP <_____) for paroxysmal episodes of presumed cardiac pain. May repeat X 1 after 5 minutes.
☐ Morphine Sulfate 2-4 mg IV q 5 min up to total of 12 mg q 1 hour (hold if BP < _____) for severe chest pain, unrelieved by NTG.
☐ Call House Officer if patient has chest pain.

Routine:
☐ Docusate Sodium (DSS/Colace) 250mg PO q day (hold for diarrhea)
☐ Enteric Coated Aspirin 325 mg po daily
☐ Other: _____

Consider:
Beta Blocker _____
Heparin _____
IV Nitroglycerin: _____

Follow-Up:
☐ At discharge fax Cardiology Clinic (x8527) for follow-up appointment within 4 weeks
☐ Smoking cessation referral (X3507 pulmonary function)

Signature:MD: _____ R.N.: _____

Date:_____ Date:_____

PT.NO.

NAME

D.O.B.

F:\CLERICAL\LNEMETH\CLINICAL\ORDERS\ACEU.DOC 10/96

UNIVERSITY OF WASHINGTON MEDICAL CENTERS
HARBORVIEW MEDICAL CENTER - UW MEDICAL CENTER
SEATTLE, WASHINGTON
PHYSICIAN ORDERS

CLINICAL PATHWAY PHYSICIAN ORDERS

UH N 0093 REV NOV 94

WHITE - MEDICAL RECORD
CANARY - PHARMACY
PINK - NURSING

LABS AND DIAGNOSTIC STUDIES

DATE	RESULTS
If patient meets ACE-U criteria: ♦ CK MB and myoglobin in ED	
♦ CK MB and myoglobin at 3 hrs	
♦ CK MB and myoglobin at 6 hrs	
♦ ECG in ED (all patients)	
♦ ECG prn chest pain (all patients)	
Non ACE-U patients/other rule out MI labs: Specified three labs: ☐_____ chest pain panel at _____ hrs ☐_____ chest pain panel at _____ hrs ☐_____ chest pain panel at _____ hrs or:_____ (early chest pain panel=CK-MB and myoglobin) (late chest pain panel=CK-MB and Troponin I)	
Pt qualifies for SPECT scan: ☐ Yes ☐ No ♦ Technetium injection within 1 hr of onset of chest pain ♦ SPECT scan within 2 hrs of injection	
ADDITIONAL LABS/DIAGNOSTIC STUDIES AS NEEDED ON DAY ONE	
SIGNATURE	**SIGNATURE**
SIGNATURE	**SIGNATURE**
SIGNATURE	**SIGNATURE**

Legend:
♦ = task intervention
[...] = outcome
* = abnormal
NA = not applicable
Ø = not done

Clinical Pathways provide guidance in the management process for a specified case type. Using Clinical Pathways in actual practice requires consideration of individual patient needs.

ADDRESSOGRAPH

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CLINICAL PATHWAY **RULE OUT MI / ACUTE CHEST PA**

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(Continued from page 157)

included different interpretations of admission criteria among physicians, nursing staff, and nursing supervisors; delays in admission to the ACE-U from the ED; and delays in nuclear medicine scanning. Delays occurred with discharges and scheduling follow-up testing. Also, work-flow issues for the staff were significant.

A small core of CICU staff members volunteered to focus their attention and time in the ACE-U. Their goal was to problem-solve and focus on quality improvement both for the patients in the ACE-U and the ACE-U itself. This group proved to be the key to the success of the ACE-U (and remains so today). The group's consistent focus and ability to problem-solve has streamlined the care of the patients and has resulted in consistent quality care for the patients.

Education of emergency department (ED) staff, nursing supervisors, attendings, and residents decreased admission and initial nuclear medicine scan time. Review of inappropriate admissions paired with education of medical staff, nursing supervisors, and ACE-U staff on admission criteria decreased inappropriate admission. Arrangements with the cardiology attendings resulted in the resident team rounding in the ACE-U prior to the intensive care units. This allowed for earlier decisions for follow-up testing and discharge. Networking with the Cardiology Department for stress testing and clinic appointments provided timely follow-up testing for patients. Additionally, evaluation of work-flow issues resulted in providing more convenient supplies, more computer work stations, and additional evening shift medical assistant support.

The ACE-U has resulted in the rapid flow of patients from the ED to the ACE-U, rapid identification and treatment of patients with acute MIs, decreased lengths of stay for patients with R/O MI, and consistent patient education and follow-up. Staff continue to identify barriers to quality care and address them individually. This staff dedication is key to caring successfully for the atypical chest pain patient. ■

EMERGENCY DEPARTMENT and CICU/3 EAST

DAY ONE

Arrival in ED (Time) _____
ECG Obtained _____
Isotope injection _____
Nuclear medicine scan _____
Admission _____

DATE

Assessment and Monitoring
VS : q 15-30 min until stable then, per routine
[Systolic BP ≥ 90]
[Hemodynamically stable]

Cardiovascular
♦ Continuous ECG monitoring
[No arrythmias]
[If (+) for MI, diagnosis made within 15 min]
[Acute drug intervention within 30 min]

Neurological
[Alert and oriented x 3]
[PERL, moves all extremeties equally]
[Behavior appropriate to situation]

Integumentary
[Skin warm, dry, intact with good color]

Respiratory
♦ O_2 per nasal cannula
[Maintains $SaO_2 \geq 92\%$]
[Lungs clear, able to clear own secretions]
[Respiratory rate regular, unlabored]

Medications
♦ Aspirin
♦ NTG SL prn
♦ MSO4 prn

♦ Consider need for other anti-ischemic therapy:
- Beta blockers
- Heparin
- IV NTG

♦ Thrombolytics per ST-segment score for uncomplicated MI patient

Pain Management
♦ Pain location, radiation, assoc. symptoms and relief
Describe _____
Time pain started: _____
Pain scale introduced (0-10) current level _____
[Pain level is acceptable to patient or pt is without pain]
Pain reassessed q 15 min until relief

SIGNATURE
SIGNATURE
SIGNATURE

Consults/Diagnostic Studies
♦ 12 lead ECG within 15 minutes and prn chest pain
♦ O_2 saturation prn
♦ CBC, M7, PT, PTT
♦ UA, CK MB
♦ CXR
♦ Cardiology notified within 30 minutes of arrival
♦ *If patient meets ACE-U criteria*:
CK - MB and myoglobin (early chest pain panel) in ED = Time 0 ☐, at 3° ☐, and 6° ☐
♦ Technetium injection stat (notify radiology MD or nuclear med if pt meets ACE-U criteria)
♦ SPECT scan within 2 hours of injection

♦ *Non ACE-U patients/other rule out MI labs*:
specify three labs ordered (late cp panel=CK-MB & Troponin I)
☐ ____ chest pain panel at _____ hrs
☐ ____ chest pain panel at _____ hrs
☐ ____ chest pain panel at _____ hrs
or: _____
_____

Fluid/Volume
[Abdomen soft]
[Bowel tones WNL]
[Stool guaiac negative]
[No nausea or vomiting]
Activity/Safety
[No falls or seizure activity]
♦ Siderails up

Psychosocial/Emotional
[Appearance and affect appropriate to situation]
♦ Screen for ETOH/drug abuse, neglect, abuse, prolonged stress or confusion

Patient Education
♦ Need for diagnostic tests discussed: pt/family
♦ Pain scale instructions given & request pt. to notify RN of increased pain & pressure
♦ Instructions given re: diet, risk factors, exercise, weight, BP

Discharge Planning
[Pre-hospitalization, patient lives independently and/or has adequate support]
♦ Consider elective cath or stress test as needed
♦ If (+) for MI, pt placed on Uncomplicated MI pathway

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CLINICAL PATHWAY **RULE OUT MI / ACUTE CHEST PAIN**

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CLINICAL PATHWAY REV 3/98

AMBULATORY CARE
QUARTERLY

New rules may slash pay for outpatient services

HCFA Medicare regs can mean cuts of up to 15%

New HCFA billing regulations for Medicare patients would have an unprecedented impact on your bottom line for outpatient and emergency services, experts say. The proposed regulations would lower reimbursement and put some EDs in financial jeopardy, predicts **Michael Bishop**, MD, FACEP, vice president of the American College of Emergency Physicians (ACEP) in Dallas.

"Obviously, if you cut up to 15% of patient reimbursement for emergency services, that will have a significant financial impact on the hospital," Bishop says. "If your costs are going up and your payments are cut, then it's a double whammy."

The financial impact may be so devastating that some hospitals may have to close their doors. "You need to be concerned about the financial viability of your institution," warns **Mason Smith**, MD, FACEP, president and CEO of Lynx Medical Systems, a Bellevue, WA-based consulting firm specializing in coding and reimbursement for emergency medicine. "There could be huge shifts in volume of outpatient surgery in competitive markets. The need to meet the competitive price may affect the financial viability of the institutions, and it will definitely affect their cash flow."

"This is so broad-sweeping, it has potential financial ramifications for literally every ED in the country," emphasizes Bishop, who served on an ACEP task force that commented on the regulations.

The long-awaited plan from the Health Care Financing Administration (HCFA) in Baltimore will shift outpatient reimbursement for hospitals into ambulatory patient classifications (APCs) similar to the diagnosis-related groups (DRGs) for inpatient payments.

The proposed system groups more than 5,000 outpatient codes into 346 payment groups, or APCs. "Each APC has been constructed to include a related group of clinical services for which Medicare will reimburse hospitals at a single, predetermined rate," Smith explains. "So APCs substantially reduce the number of payment levels that need to be tracked."

To define the clinical services included in each APC, HCFA will use the same coding system currently used to reimburse physician services for Medicare patients, known as the current procedural terminology (CPT) system.

"This would be a major change in how billing is done. It represents the same magnitude of change as the switch DRG has had on the inpatient side," says **Charlotte Yeh**, MD, FACEP, medical director for Medicare policy at the National Heritage Insurance Co. in Hingham, MA.

This is the biggest reimbursement change in Medicare billing since 1982, when the Tax Equity and Fiscal Responsibility Act was passed, Bishop says. "That caused many emergency physicians to do their own billing instead of the hospital. This change will have no less of an impact on EDs."

The regulations will control the growth of Medicare expenditures for hospital outpatient services the way the DRG reimbursement system controlled inpatient expenditures. "The Medicare strategy is simply to treat hospital outpatient services exactly the same way as they treat physician office services, which is a totally new approach," Smith says.

Explains Bishop, "This is a move by HCFA to decrease Medicare costs, which is not a bad thing, but there are potential problems. In the ED, we can't control the patients we see, so we see the sickest patients. If the amount of revenue goes down for the hospital, we will have less money to provide the same services."

As a result, patient care could be affected. "This can certainly affect patient care if there is not as much money coming in to the hospital. Decreased payment could result in decreased staffing, equipment, and supplies," Bishop says.

Some hospitals will be affected more than others, he warns. "Teaching institutions and large inner-city hospitals — any hospital that has a

high percentage of high-acuity or Medicare patients — will be hit the hardest."

Hospitals should expect less payment for outpatient services provided to Medicare beneficiaries, both from Medicare payments and copayments from beneficiaries, says Smith. "HCFA predicts reductions in direct payments from the Medicare program amounting to 3% to 15% of current revenue. The actual impact on individual hospitals will vary based on the hospital's current cost-to-charge ratio."

Although ED patients already are guaranteed access to care under the Emergency Medical Treatment and Active Labor Act, financial ramifications could create barriers to care, Yeh stresses. "If the payment levels are insufficient, you might not only see hospitals closing, but some hospitals may pull out of outpatient and emergency services," she predicts. "If that happens, it will create an access problem."

Copayments will be reduced from current levels by an unspecified amount. "Estimating the amount of this reduction is very difficult," says Smith. "Comparing the maximum and minimum copayment amounts for common procedures suggests that the eventual reduction will average 13% of total payment. More than 50% of the revenue reduction will result from lower beneficiary copayment."

The impact on hospitals will depend on the amount of copayment they charge. "A hospital has to choose whether to charge the maximum or minimum allowable copayment, or some number in the middle," says Smith. ■

Wound care program boosts revenue, patient care

More rehab departments embracing the concept

The old saying, "When one door closes, another opens," might apply to the use of wound management programs by rehabilitation departments. The same rehab departments that are stretched thin in terms of commercial and Medicare reimbursement are building revenue and improving patient outcomes through wound care and wound management.

Adding wound management services can generate between $200,000 to $457,000 in revenue annually for a hospital, depending on the size of the institution, says **Pam Unger**, PT, partner and clinical director of The Center for Advanced Wound Care in Wyomissing, PA.

"After our first eight months [of operation], we've been a money maker," she says. "This is an area that's booming across the entire country. There's still reimbursement for it. [Wound care] has been identified as something that exists and needs to be treated. [Rehab departments should] try to intervene with a service that's revenue-generating but also produces a positive outcome."

Although not a new concept, the area is rapidly being embraced by therapists. More than 20% of physical therapists responding to a survey sponsored by the Alexandria, VA-based American Physical Therapy Association (APTA), the wound management special interest group, say wound care management should become a recognized specialty in the physical therapy field, says **Carrie Sussman**, PT, president of Sussman Physical Therapy Inc. and Wound Care Management Services in Torrance, CA.

"More than 1,100 respondents felt it should be a part of the practice of physical therapy. Eight hundred specifically said that it is part of their practice," says Sussman, a frequent consultant on wound management in physical therapy.

"Historically, therapists got into wound care via hydrotherapy, such as Hubbard tanks. But today, it has evolved to where therapists are doing open wound care. We've taken it to a more defined role," says **Cordell Atkins**, PT, a certified wound specialist who is a senior therapist and crew leader at Intermountain Health Care in Salt Lake City. Atkins also serves as chairman of APTA's wound management special interest section. "But in our physical therapy role, we have to demonstrate a functional outcome. If we're working with pressure ulcers, we may also have mobility activities or positioning activities. If I look at diabetic wounds, I may look at gait activities, pressure reduction, total contact casting, or [shoe] insoles or inserts."

The common denominator among hospital rehab programs that have implemented wound management techniques seems to be the presence of a therapist interested in this area. For example, Unger entered the wound management area in 1981 when working in a nursing home. "Every time I had a patient with a wound, the wound got in the way of rehab. A patient wouldn't be able to do his exercises or ambulate because he had a wound in his heel, for example," she says.

After doing some research and attending continuing education courses on wound management,

Unger decided to develop a PT-directed wound care center, operating first out of the hospital's inpatient therapy department and eventually as a wound clinic within the hospital. Initially, she worked as a consultant three days a week, helping the department beef up its wound management program and dealing with patients who had specific wound management needs.

Growth occurred gradually

It didn't take long to establish a patient base. Because the hospital rotated therapists among inpatient care, acute care, and other rehab settings, Unger developed a good referral base between staff therapists and hospital physicians. "I took orders that came down from the physician, assessed the patient, and called the physician to discuss a care plan. The only outlay [to the hospital] was the cost of using me as a consultant." Unger billed a consultant's hourly fee to the hospital.

Eventually, Unger's patient load grew large enough to justify establishing an on-site wound management department with ancillary clinical services at the hospital. "Initially, it was just me and a receptionist, and later we added a physical therapy assistant," she says. As patient volume increased over the years, The Center for Advanced Wound Care gradually grew to its current staff of nine. The center also added a satellite office with a staff of four.

"Don't think you need to do it all on day one," advises Unger, who consults with hospital rehab units hoping to start a wound management program. "We have our best success with clinics when we start small and progress and grow."

Atkins' involvement in wound management has led to the development of a physical therapy team specializing in wound management at Intermountain. Atkins and a partner, another physical therapist, work a seven days on / seven days off 10-hours-per-day schedule. The physical therapy team receives referrals from hospital and outpatient physicians — including plastic surgeons, general surgeons, orthopedists, endocrinologists, internists, family practitioners, and podiatrists — as well as hospital-based nurse practitioners and physician assistants. The physical therapy team is able to treat the patients in their rooms or in the hospital physical therapy department, depending on the patients' needs.

Hospitals shouldn't expect to see this kind of patient volume immediately, however. Atkins has been providing wound management services for more than 17 years.

At the Veterans Administration Medical Center (VAMC) in west Los Angeles, the rehab department has seen subtle changes rather than dramatic ones since it began offering wound management treatment two years ago, says **Randi Woodrow**, PT, manager of physical therapy at the hospital.

"We're using staff time in a better way, and the costs have been minimal," she says, adding that the hospital has not totaled the costs of adding the program because funds were drawn from the department's continuing education budget.

Sussman instituted a wound management program for a skilled nursing facility to treat patients with severe mobility impairments who had developed pressure ulcers. She found that the treatment improved patient recovery time and became an additional source of revenue for the facility. She since has branched out into a specialty in wound management consulting for physical therapists and has co-written a book titled *Wound Care: A Collaborative Manual for Physical Therapists and Nurses.*

VAMC's decision to enhance its wound care program was driven by the physical therapy department, Woodrow says. "We had a physical therapist who came to us with wound care experience," she recalls. "We didn't know what we were missing. She shared current information and education with us. It was really through her pushing that we identified that our knowledge wasn't as current as it could be."

The hospital used Sussman to train some of the staff therapists as well as educate its attending physicians and residents, who primarily are physiatrists, Woodrow explains. After the presentation, the hospital's staff therapists invested time in educating physicians one-on-one.

"It was really very time-consuming. Traditionally, physicians would order a whirlpool treatment [for a patient with a wound infection] followed by betadine. Our message was that there are methods that are less invasive and more cost-effective" such as collagenase or hydrophilic dressings, she says. "It was a process. It wasn't like we decided to do it one day and had approval the next. The entire process [of educating physicians] probably took a year."

Sussman agrees that physician buy-in is essential to starting a wound-management program. "Pitch it as another revenue-generating center," she suggests. "It's almost like taking your car in to be repaired. Your first two questions to the

mechanic are, 'When can I get my car back?' and 'How much [will it cost]?' Similarly, physicians want to know when [you plan to implement the program] and what are the expected results. And what research do you have to back it up?"

Woodrow says that although her department has not documented the cost and outcomes of wound management treatments vs. the whirlpool treatments typically recommended by the physicians, she has no doubt that the wound care techniques are saving time and money.

Physician support is just part of the multidisciplinary team effort needed for a successful wound management program, say Sussman and Unger. "I pretty much did it all on my own initially when I started this in 1981, but you just can't do that [today]," Unger asserts. "You're not with a patient 24 hours a day. You need nurses, dietitians, and specialists like podiatrists or plastic surgeons."

Program needs multidisciplinary approach

If you think of the traditional wound management program as changing dressings that contain high-tech medications, you're missing the boat. Effective wound care involves collaboration among therapists and other staff clinicians, as well as frequent monitoring of patient outcomes, according to therapists with wound care experience.

If your rehab department is considering adding a wound care program, these pointers may help:

1. Wound management takes a multidisciplinary approach. "It's very obvious that [therapists] don't have all the answers," Sussman says. She recommends working very closely with nurses, who frequently are the referral sources for wound healing treatments by physical therapists. Both parties need to explain the treatment each is providing to the patient and the expected outcomes and should make certain they are compatible.

Unger says her center, The Center for Advanced Wound Care, was created with a team concept in mind. She serves as clinical director, and a physician serves as medical director. The center also includes a wound care department and a wound management department. The latter includes diabetic educators, vascular services, and podiatrists, who serve as consultants.

2. Approach the patient when developing outcomes. Patients should be a key part of the outcomes goal-setting process, Sussman says. "It's not always as obvious as one might think. I once saw a patient who came in with a very heavily draining wound that had a lot of pus and odor. It was keeping her confined to home. What she wanted was to be able to control the odor so that she could get out of her house and go to church on Sundays and to see her family. That was her desired outcome."

3. Distinguish between wound care and wound management to receive proper reimbursement. "Wound care, including wound cleansing, administration of topical pharmaceuticals, and dressing changes, is typically considered a nursing service," Sussman says. "To distinguish the services of the nurse from those of a physical therapist, think of the physical therapist performing wound management, which incorporates the evaluation process of the physical therapist and the selection of interventions. It may also include the administration of these interventions or instruction, along with the wound care.

"In order to be considered a [reimbursable] PT service, it must include a service that is unique and that specifically requires the skills of a physical therapist. Examples might be: selecting electrical stimulation protocols, or sharp wound debridement accompanied by another service, such as whirlpool or pulsatile lavage with suction. Also, rehab may be a part of the wound service, such as treatment of an amputee who is undergoing gait rehabilitation," she says.

4. Develop a protocol for your wound care program. For a sample pathway:

- Include wound assessment as part of the initial evaluation done by the physical therapist.
- Determine if any interventions are needed to heal a wound or prevent a future wound from developing.
- Determine the type of intervention needed.
- Communicate the information to the attending physician or other appropriate parties.
- Determine who does what tasks. For example, who changes the dressing? It isn't always the nurse. "Therapists are qualified to put on a dressing and topical agents, if they're doing it in the course of providing therapy," Sussman says.

At VAMC in west Los Angeles, the protocol involves team rounds of all patients who are at risk for wound problems, says Woodrow. If team members see a patient at risk for developing wound problems, they will add recommendations to the patient's chart, whether it involves a dressing change or a treatment in the physical therapy gym.

At The Center for Advanced Wound Care, patients are classified into a specific category based on the type of treatment needed, following

an initial 2.5-hour visit that includes an assessment by a physical therapist and a physician and patient history data provided by a registered nurse. Patients are classified as post-surgical, traumatic, or burn patients.

The center also might use basic admitting and treatment protocols that go with each category, at least as a starting point. "The physical therapist writes a plan of care [based on these protocols] with input from team members," Unger says.

"Based on the type of case, it might include ultrasound, pulse electromagnetic induction, dressing changes, total contact casting, and exercise programs from the therapist's perspective. It also might include antibiotics or nutritional education. But the plan of care may change as things happen with the patient," she says. Once a week, the clinic has all professionals involved in the care — from surgeons to nurses to other providers — meet to review the patient's progress.

5. Don't forget about prevention. Spinal cord injury patients and stroke patients are among those who frequently are at risk for wound problems, Sussman says. Prevention planning could be part of an initial evaluation as well as ongoing patient assessments.

6. Remember: There is strength in numbers. The APTA has a wound management special interest group that is part of its section on clinical electrophysiology. Contact the association at (703) 684-2782 or on the World Wide Web at www.apta.org.

APTA files class action suit

In addition to acting as a resource, the group has gotten involved in reimbursement issues affecting wound management in rehab settings. For example, APTA filed a class action suit against the Health Care Financing Administration protesting HCFA's refusal to cover electrical stimulation by therapists for wound management purposes. The suit led to a court ruling that required HCFA to consider reimbursement for these services on a case-by-case basis.

7. Research costs and desired outcomes when beginning a program. Potential sources include the National Pressure Ulcer Advisory Panel, which holds regular conferences and is planning a conference for Oct. 6 in New York City. Contact the organization at (314) 909-6815. Sussman's book, *Wound Care: A Collaborative Manual for PTs and Nurses*, written with Barbara Bates Jensen, RN, is available from Aspen Publishing Co. for $85. ■

(Continued from page 156)

Members of ACMA will be able to take advantage of the following services:

1. A job opportunities network.

Hospitals will be able to post vacant positions relevant to case management staff and leadership. Case managers seeking employment will be able to review the postings and respond directly to the posting organization.

2. An information resource center.

The ACMA resource center will house generic tools such as job descriptions, salaries, national case management survey data, case management literature references, and Web site references. These resources will be available to requesting members.

3. A directors forum.

A forum will be established for directors of case management at ACMA's first annual meeting, to be held in conjunction with the Little Rock, AR-based National Institute for Case Management's next Clinical Case Management Conference, which will be held April 24-27 in Las Vegas.

The forum will allow directors an opportunity to "identify a year 2000 agenda for issues related to case management," Cunningham says. The directors also will be developing a national case management survey, which ACMA will sponsor. The results of this survey will be made available to the membership.

4. A mentoring service.

Individuals who are just becoming case managers or directors of case management will be able to link with another ACMA member who has volunteered to serve as a learning partner. "There will be various levels of mentorship," Cunningham says. "On one level, the mentoring may take place through the Internet and e-mail. A second level may involve interactive conference calls in addition to e-mail."

Annual membership dues for ACMA are $135. **(See application sheet, inserted in this issue.)** Those who join by the end of 1999 will be the charter members. Their memberships will be valid through the end of 2000.

"With health care as unpredictable as it is and hospital leadership depending more on case management as its 'solution provider,' ACMA is gearing up for the challenge to assist its members in collaboratively providing solutions for their success," Cunningham says.

For more information, call the ACMA office at (501) 907-2262. ■

How to develop effective pain management policies

JCAHO turns the spotlight on pain assessment

Too often, otherwise effective treatment plans ignore the need for routine pain assessments, experts say. Unfortunately, without routine assessment and adequate education about effective pain management, the pain symptoms of many patients remain undertreated.

The Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, recently addressed the need for more effective pain management by revising its standards for managing pain in all settings, including acute care.

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

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

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

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

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

Young says these psychosocial issues should be included in a pain evaluation:

KEY POINTS

- By building effective pain management strategies into the treatment plans they develop, case managers can eliminate needless suffering and possible delays in healing among some patients, experts say.
- To ensure a thorough pain evaluation, experts recommend that case managers include the following examination elements: a chronological history of the pain; activities that make the pain better or worse; ability to perform activities of daily living; possible underlying disease processes; therapies tried in the past for pain relief; and a complete list of medications taken for pain and other conditions.
- Possible elements to include in your own pain management policies include: systematic and ongoing assessment of pain symptoms; systematic use of appropriate medications; combining pain medications with non-drug therapies; measuring pain management outcomes; and ongoing quality improvement assessments.

COMING IN FUTURE MONTHS

- How to resolve turf battles between case management and nursing
- What case managers must know about their facility's corporate compliance plan
- Building an infrastructure for a successful case management program
- Special report: The ethics of hospital-based case management

• family dynamics;
• work situation;
• emotional cycles;
• history of treatment for depression or other psychiatric disorders.

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

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

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

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

Often the biggest obstacles case managers must overcome in advocating for more effective pain management is the fear common to both physicians and patients that use of certain pain medications may lead to addiction, say Young and Curtiss. "I could just beat my head against the wall sometimes over that one issue," Curtiss says. "There is a fear of use of opioids when, in truth, appropriately used, the risk of addiction with these drugs is less than 1%."

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

"There are a number of physicians uncomfortable using more heavy-duty medications due to lack of information about proper prescribing habits," Young says. "They fear subjecting patients to addiction potential."

However, there is little danger of addiction to pain medications if physicians follow guidelines established by the Agency for Health Care Policy and Research in Silver Spring, MD, which outlines a disease management approach to chronic pain, Young says. "It's a stepped-up approach which starts at the safest and least addictive options and progresses to more powerful drugs only as needed."

She adds that it's important for both payer- and provider-based case management programs to have a clear pain management policy. "It's difficult to know if you are managing pain well if you don't have a written standard of care that defines pain management. In addition, most

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health insurers have no clear-cut policies for reimbursement for pain relief. This leads physicians to err on the side of caution and leaves patients undertreated."

"The nice thing about developing a pain management policy is that the standards are clear among organizations about how to assess and manage pain," she notes.

Curtiss recommends case managers include these elements in their own pain management policies:

- systematic and ongoing assessment of pain symptoms;
- minimum required assessment frequency of once each visit in the home care setting and once each shift in the inpatient setting;
- standard for the level of pain that requires a review of the pain management plan;
- systematic use of appropriate pain medications;
- evaluation of the effectiveness of pain medications;
- combining pain medications with non-drug therapies, such as heat, cold, relaxation, and imagery;
- measuring pain management outcomes;
- ongoing quality improvement assessments. ■

NEWS BRIEF

HFMA updates training kit on three-day window rule

The Healthcare Financial Management Association (HFMA) in Chicago has updated a training kit designed to help hospitals comply with Medicare's three-day payment window rule.

The rule is a Medicare regulation requiring bundling of all diagnostic and certain nondiagnostic services performed within three days of an inpatient admission on the same inpatient bill to Medicare. It applies only to acute care hospitals.

"DRG Watch: Complying with the 3-Day Window Rule" is an updated version of "DRG Watch: A Multi-Phase Instructional Program for DOJ Compliance," which HFMA launched in 1996.

The revised program features information based on the Health Care Financing Administration's final three-day window rule, published in February 1998. It includes a training video, a desk reference guide / workbook, audio teleconferences, and custom advice through HFMA's Knowledge Network. ■

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. ■