

HOSPITAL CASE MANAGEMENT™

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

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Case managers, utilization reviewers team for cost savings of \$3.6 million

Care designs correspond to top DRGs

By tracking length of stay and direct variable cost of care, the case management department at Covenant Health System, based in Knoxville, TN, was able to show a savings of \$3.6 million in the first three quarters of last year and a denial rate of less than 1% at most of its facilities.

"We looked at length of stay and cost per case and were able to show that we got a low denial rate because of the case managers working closely with the utilization review staff," says **Sandra Marshall, RN, MSN**, senior vice president, organizational effectiveness/clinical outcomes for the five-hospital system.

The heart of the case management system is Covenant Health System's Clinical Resource Management system, which includes 16 care designs, or clinical pathways, for the health system's top diagnosis-related groups (DRGs). (See sample care design pages, pp. 35-36.)

Teams of physicians, nurses, and other clinical staff from across the system developed the care designs. The team members changed depending on the diagnosis. For instance, pharmacists were on the team that developed the pneumonia DRG.

The team used its computerized decision-support tool to identify physicians with the lowest length of stay, lowest cost, and excellent outcomes, and developed best practices using the successful physicians' treatment plans and evidence-based medicine research.

"For each DRG, we came up with what we believe was the best care design for any patient in our system, based on best practices and key things we knew we had to do," Marshall says.

The care designs include the core quality measures tracked by the National Hospital Reporting Initiative of the Centers for Medicare & Medicaid Services (CMS) and the Joint Commission on the Accreditation of Healthcare Organizations.

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"Our case management work has prepared Covenant Health for public reporting," Marshall points out. For the baseline year, 2002, the system tracked direct variable costs per case and length of stay for each of the 16 DRGs.

Data from the first three quarters of 2003 showed the \$3.6 million reduction in costs, a figure that she anticipates will increase as time goes on. "The care designs use evidence-based medicine. It's going to take a while to get every-body cranking on this," she says.

The health system has been working on its plan for about 2½ years. It took most of 2002 to get all the care designs drafted and ready to go into place, Marshall points out.

The health system has tried to implement clinical pathways without a lot of success in the past. "Part of the work I was charged with when I came here was to help the executive vice president put together a clinical resource model and move it through the system," she continues.

One of the larger hospitals in the system, Methodist Medical Center (MMC) in Oak Ridge, TN, already had an active critical pathway program, called CareTrax, which started in 1993. **(For details on how the CareTrax system was implemented, see related article, p. 37.)**

At the time the care designs were started, 100% of MMC's patients were on a CareTrax, either a specific program or a generic track for patients who didn't fit the regular one, explains **Coletta Manning**, RN, MHA, CPHQ, director of clinical effectiveness and quality improvement.

MMC adapted the 16 core care designs that were adopted systemwide and has continued using other care designs it already had in place. For instance, the hospital still uses its CareTrax for carotid endarterectomy and myocardial infarction.

The hospital has been tracking length of stay for all CareTrax DRGs since launching the CareTrax program in 1993. Manning's department pulls data for each medical group, depending on when they meet. The hospital's orthopedic section meets once a month and also receives its data once a month.

The data include total costs of care and variable direct costs, such as laboratories and X-rays, as well as the reimbursement the hospital receives for the services.

"It's important for the physicians to see the reimbursement received. We look at what costs we can cut, but if the reimbursement is less than the cost, the hospital is still dead in the water," Manning says.

The physicians are eager to get their data because they show how well they are doing, she adds. "They especially look forward to when we look at how we compare to other facilities."

When patients are admitted to any hospital in the Covenant system with a DRG for which there is a care design, the case managers enter the code into the system.

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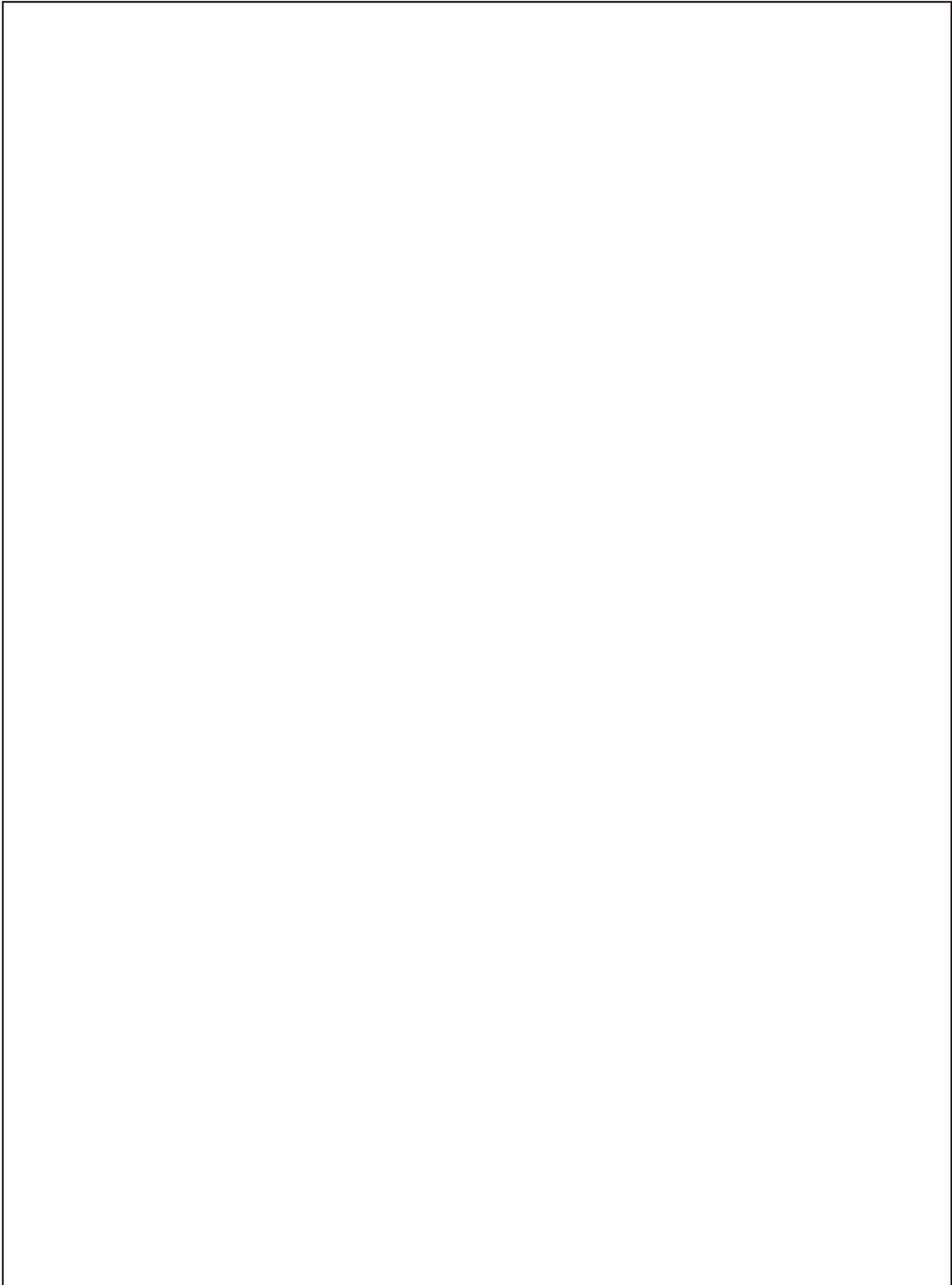
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Source for both charts: Covenant Health System, Knoxville, TN.

(Continued from page 34)

If the patients come into the emergency department (ED), the case managers get them started on the care design there.

If the patient is being treated by a hospitalist, he or she automatically goes on the care design.

"If the physician is one who doesn't buy into the pathway idea, when the patient gets to the unit, the case manager manages the care as if the patient were on the pathway, Manning adds.

The system allows the case management department to track what percentage of the patients assigned to a particular DRG had the care plan in use, she says.

The fact that the health system has hospitalists across the system was a big plus when it came to implementation of the care design program, Marshall points out. "Through their contracts, they have an incentive to work with us collaboratively."

The case managers spend a lot of time working with hospitalists at the larger facilities.

The hospitalists receive a report card rating

them on the use of the care paths, utilization, patient satisfaction, and compliance in meeting Joint Commission core measures. "We measure them on achieving specific lengths of stay for the DRGs under their purview," Marshall says.

The case managers know the target lengths of stay for each of the 16 DRGs the department tracks. If the patient has a condition covered under the CMS and Joint Commission core measures, they make sure the goals and objectives are being met.

With the core measures, the case managers know by the order set what the core measures, goals, and objectives are. They prompt the physicians to document and make sure that the appropriate measures were taken. For instance, they make sure that patients with congestive heart failure were given ACE inhibitors.

Physicians get letters identifying when patients met the criteria for the core measures and didn't receive the care.

At MMC, Manning has assigned her case managers by service, giving them expertise in handling the patients whose care they manage; the

Physician champ helped gain acceptance of clinical pathway

Aim was to improve quality, reduce variations in care

A physician champion made all the difference when Methodist Medical Center (MMC) in Oak Ridge, TN, started its CareTrax clinical pathway system in 1993, says **Coletta Manning**, RN, MHA, CPHQ.

"We had a physician jump on the bandwagon right away and because of him, quickly got the other doctors on board. We have an excellent group of physicians who very rapidly understood that if we improve quality by reducing variation in the care, it made their job easier," adds Manning, the hospital's director of clinical effectiveness and quality improvement.

She started her critical pathway initiative with total hip replacement patients, taking their charts and creating abstracts she put on a grid that documented the day-to-day care of each one.

For instance, in the case of one patient, she showed that the physician didn't consult the discharge planner until the patient had been hospitalized for five days and that increased the length of stay.

In another case, Manning showed that the Foley catheter was left in four days instead of one because the physician forgot to write the order to remove it, and the patient got a urinary tract infection that kept him in the hospital longer.

She showed instances where the antibiotic that was prescribed was more expensive than one that was considered a standard of care and had the same effect.

"I showed them a lot of examples and asked if we could put the best practices together and have one physician try it to see how it works," Manning says.

The physician who did the highest volume in the group jumped at the chance to try the CareTrax.

"He had great outcomes and was the highest-volume producer and had very good results with the CareTrax. I took the idea to every department and soon had physicians asking for CareTrax for their departments," she continues.

When physicians told Manning that the CareTrax system was cookbook medicine and their patients were different, she had a ready answer. "I told them that I was sure they had a recipe in mind of all of the things they were going to do for every single one of their patients when they came into the hospital, and I wanted their recipe," she says.

Manning also attributes the success with the pathways to the fact that theirs is a stand-alone hospital and 99% of the physicians send all their patients to MMC. "They have a stake in it because they want us to stay open," she adds.

Manning has been at MMC for 29 years and has known many of the physicians for a long time.

"I came up through the ranks. I worked on the unit and have been in quality a long time, so there is an element of trust," she says. ■

case manager assigned to cardiology once worked for the cardiology group.

The case managers do concurrent review on all patients and make sure they are in compliance with the core measures. For example, if a patient comes into the ED with a myocardial infarction, the case manager makes sure he or she is on beta-blockers.

The case manager is knowledgeable about cardiology and looks through the chart to see if there is a reason the beta-blocker may be contraindicated. If not, she can check with the physician to make sure it's ordered or that the reason it's contraindicated is documented.

"All our case managers are out there on a concurrent basis. If you examine the charts retrospectively, it doesn't do much good," Manning says.

On a systemwide basis, the case management departments still are working to get all of the patients in the system admitted under the 16 DRGs into the system and continuing to work to get physician buy-in.

The obstetricians bought into the care design system immediately and are 100% in compliance. The orthopedic surgeons have accepted the idea as well. "It's been easier for the surgeons than on the medicine side," Marshall says.

The system currently is profiling individual physicians by DRG. The profile compares each physician's direct various cost and outcomes to those of his or her peers. The profiles do not identify the physician by name at present, but most of the medical staff know who they are, she adds. "We are hoping this will leverage the rest of the physicians who haven't bought into the care design initiative when they see what the guys who are really successful are doing."

The nursing plan of care is automated on the hospital's case management software. The hospital is moving toward a computerized physician entry program, which the hospitalists will pilot.

The system tracks denial rates each quarter, tabulating information such as what percentage of payers have denials, why they were denied, and who the payer is.

Each facility has a denials management team on which the director of case management serves. The team examines each individual denial to see why it occurred. In as many cases as possible, the team deals with the denial while the patient is still in the hospital.

If the utilization review nurse gets an indication from a health plan that a patient day may be denied, she alerts the case manager.

If it's a question of documentation, the case manager works with the physician to document appropriately. If the patient is ready for discharge, she cranks up the discharge planning process, Marshall says.

Each case management department in the system gets a monthly length of stay report showing how the department met the targets in length of stay and decrease in direct variable costs. The department meets as a whole and looks at ways to improve on meeting the targets.

"The facilities know what is going on and are able to make sure people are held accountable. Accountability is a biggie with us. Everybody knows what our goals and objectives are and works with the team to get them done," she says.

Dealing with insurance downgrades

One problem Marshall's staff have been dealing with recently is a push by insurance companies to downgrade days and pay skilled nursing reimbursement for acute care days.

"In my mind, this is unacceptable. I have tried to tell them that acute care facilities are not licensed as skilled care facilities and that if a member receives acute care services, we should be paid for that," she explains.

In some cases, the carrier tells the hospital that the patient's condition warrants only skilled nursing care, not acute care, and that the patient should be discharged.

"If we have fallen down on the job and not done appropriate discharge planning, we have to own up to that," she says.

The case managers at Covenant Health are assigned by unit and by disease process: The cardiac case manager tracks the heart attack and congestive heart failure patients.

The three tertiary care centers have case managers who are RNs and utilization managers who are a mix of RNs and LPNs.

"Our case managers can do utilization review if necessary, but they are more focused on managing the patient care," Marshall says. The two functions are separate even in the small rural hospitals, she adds.

"We want to make the most of the case managers' potential to gain leverage in our length of stay," Marshall continues. They are cross-trained to do utilization review, but there is a separate utilization review staff to manage the

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CRITICAL PATH NETWORK™

Type of data plotted determines which control chart to use

Selection critical to having correct control limits

Correct control chart selection is a critical part of creating a control chart, according to PQ Systems, an industry leader in the manufacturing of statistical process control (SPC) and quality control software based in Miamisburg, OH.

"If the wrong control chart is selected, the control limits will not be correct for the data," states the company's web site (www.pqsystems.com). "The type of control chart required is determined by the type of data to be plotted and the format in which it is collected."

"SPC is a methodology for charting the process and quickly determining when a process is out of control [e.g., a special-cause variation is present because something unusual is occurring in the process]," according to **Sid Sytsma**, MSE, MBA, professor in the College of Business at Ferris State University in Big Rapids, MI, and an expert on SPC.

"The process is then investigated to determine the root cause of the out-of-control condition. When the root cause of the problem is determined, a strategy is identified to correct it. The investigation and subsequent correction strategy is frequently a team process, and one or more of the TQM [total quality management] process improvement tools are used to identify the root cause," he says.

Reduced variation, Sytsma explains, makes the process more predictable, with process output closer to the desired value.

According to **Steve David**, MBA, president and CEO of SkyMark, a Pittsburgh-based manufacturer of SPC software, all control charts have three basic components:

- a centerline, usually the mathematical average

of all the samples plotted;

- upper and lower statistical control limits that define the constraints of common-cause variations;
- performance data plotted over time.

It is from those common points that the different types of control charts flow, dictated by the type of data and format.

The first determination that must be made in deciding what type of chart to use is whether you are dealing with attribute or variable data.

"In general, attribute data are *count* data," notes **Marilyn Hart**, PhD, of the University of Wisconsin-Oshkosh, who lectures and writes about health care and SPC.

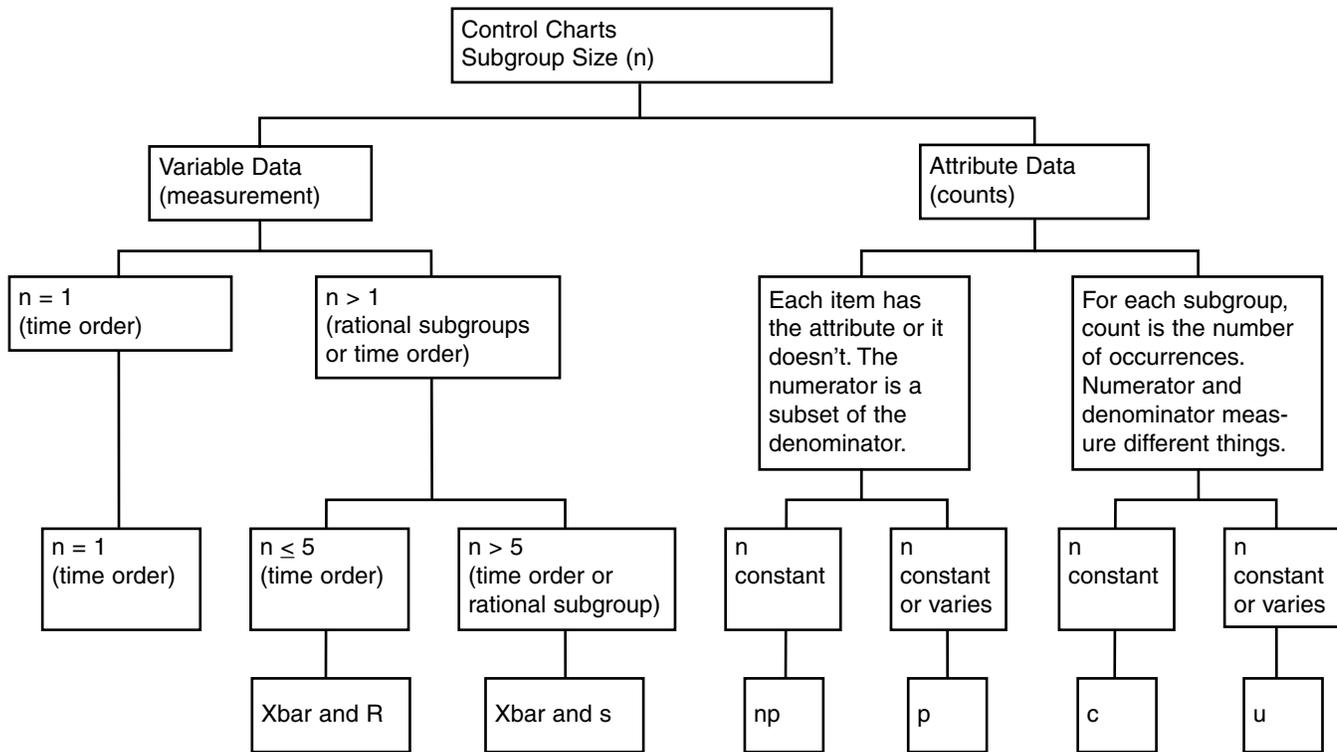
"You can *count* the number of patients attending the clinic each week, the number of patient falls, the number of C-sections, the number of births." Hart and her husband Robert Hart are co-authors of *Statistical Process Control for Health Care* (Pacific Grove, CA: Duxbury; 2002).

"This is the first decision you need to make before plotting data," adds **Patrice L. Spath**, RHIT, a consultant with Brown-Spath & Associates, in Forest Grove, OR. "Attribute data usually are the number of — i.e., surgical complications, C-sections, delinquent patient records."

PQ Systems adds this definition: "A standard is set and then an assessment is made to establish if the standard has been met. The number of times the standard is either met or not is the count. Attribute data never contain decimal places when they are collected; they always are whole numbers."

Variable data, Hart explains, are measurement data — sometimes called *continuous data*. "You measure, for example, the amount of time a laparoscopic cholecystectomy takes; you measure the

Control Chart Decision Tree



Source: Hart M, Hart R. *Statistical Process Control for Health Care*. Pacific Grove, CA: Duxbury; 2002.

amount of blood you've used; you measure the weight of the newborn infant," she says.

"It could include wait times in the emergency department," Spath adds. "Actual surgical time less scheduled surgical time; dollar amount of accounts receivable; blood pressures of a patient over a 24-hour period — things that are measured, not counted," she explains.

"Generally, a measuring device such as a weighing scale or clock produces these data," according to PQ Systems. "Another characteristic of variables data is that they can contain decimal places."

As an illustration of the difference between the two types of data, **Judy Homa-Lowry, RN, MS**, president of Homa-Lowry Healthcare Consulting in Metamora, MI, refers to an example of monitoring refrigerators in a patient unit. (See *Critical Path Network*, February 2004, p. 25.)

"If you are asking whether or not the temperature had been checked, that would be attribute data," she notes. "But it might be more important to know the range of temperatures, or to measure that range, and that would be variable data."

Determining whether you are working with variable or attribute data is fairly simple. As the

decision tree shows, all other decisions flow from determining the type of data with which you are working. (See **decision tree, above and decision matrix, p. 41.**) After that, the process becomes a bit more complex.

Hart offers the following guidelines for control chart selection when you have variables data:

If the data occur one at a time (newborn weights, time for a lap chole procedure, etc.) the chart for individuals (sometimes called an X chart or an I chart) is best. (The moving range [MR] chart to monitor the change from one reading to the next may or may not be used.)

If the measurement data are grouped by month, for example, an Xbar and s chart is best. The Xbar and s chart also is appropriate when grouping the data by rational subgroups.

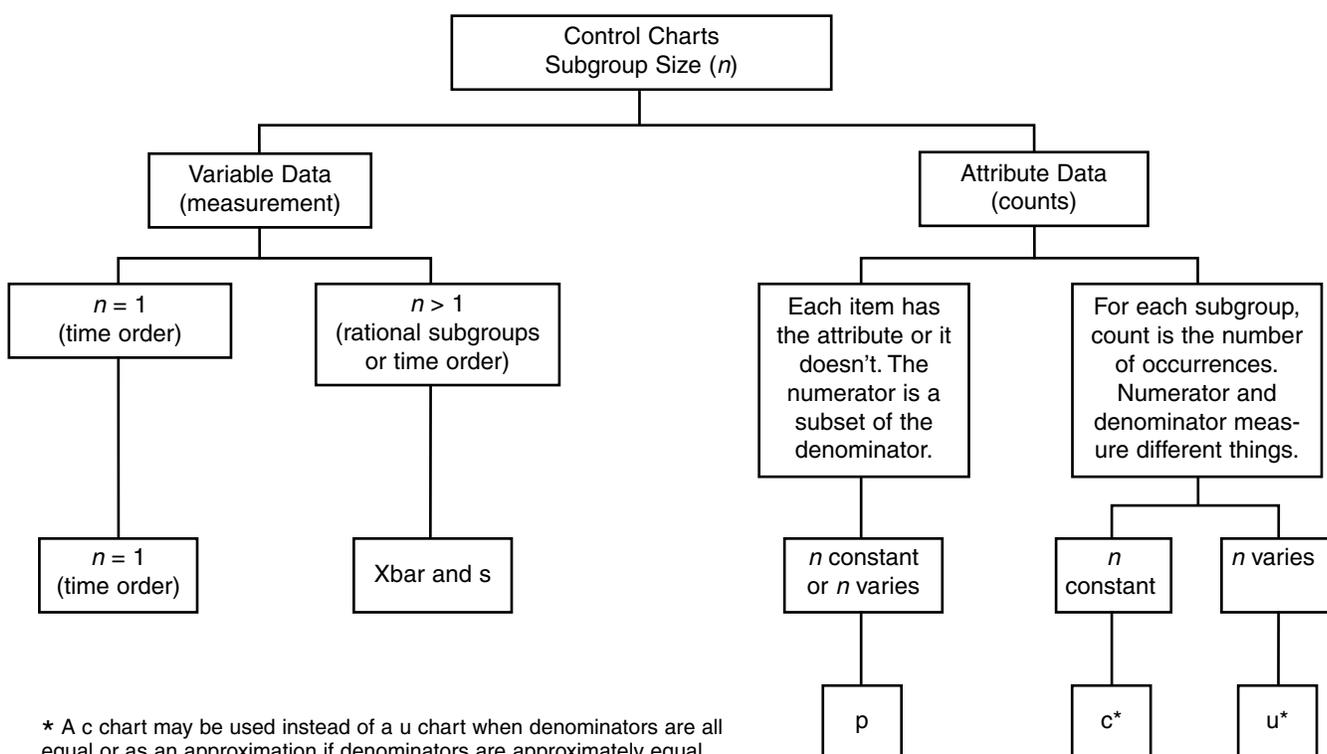
Some people also may suggest an Xbar and R chart when the data are grouped in small groups, for instance groups of five or less. However, that type of application happens so rarely and can be handled by an Xbar and s chart, that it does not seem worthwhile to learn the extra chart.

Determining whether you are working with a rational subgroup is fundamental, Homa-Lowry

Decision Matrix for Attribute Data

	Equal size subgroups	Unequal size subgroups
Count may be larger than the subgroup size	c chart (or could use a u chart)	u chart
Count is limited by the subgroup size	np chart (or could use a p chart)	p chart

The np chart is seldom used.



* A c chart may be used instead of a u chart when denominators are all equal or as an approximation if denominators are approximately equal.

Source: Hart M, Hart R. *Statistical Process Control for Health Care*. Pacific Grove, CA: Duxbury; 2002.

says. “If you were monitoring a lab and looked at the number of errors, that would be a rational subgroup. You would start plotting them maybe by week, or by month; you could also look at the total number of procedures or discharges.

“If you have more than one observation per subgroup, you would use the Xbar chart. For example, looking at the turnaround for a daily sample of five lab orders: This might be good for a small hospital, since these things don’t happen very often. If you have more than 10 per month, you would have the s chart. The Xbar and R chart would be how many lab orders do we process each week,” she continues.

“The control chart method is quite robust,” Hart cautions. “That is, it will tolerate some departures from the normality assumption and

still work rather well. So the data need only be near-normal for the control charts to work. If the data are badly skewed, which is often the case with data such as time intervals, misleading results will occur. Points may occur outside the control limits due to the skew of the data, not due to any special-cause variation.

“A pattern also will occur on the Xbar and s chart. In particular, if the data are skewed to the right, the values plotted on the Xbar chart will be in phase with the values plotted on the s chart. That is, they will go up and down together. If the data are skewed to the left, the values plotted on the Xbar chart will be 180° out of phase with the values plotted on the s chart — that is, when one goes up, the other goes down. A histogram and a probability plot must be made before a control

chart is made to see if the data are badly skewed. If so, a transformation may be made to make the data near-normal before the control chart is made," she explains.

Hart notes that attribute data must be further subdivided into two categories.

"Each item has the attribute or it doesn't," she observes. "One example could be C-sections. Each delivery either was a C-section or it wasn't, and the number of C-sections cannot exceed the number of deliveries. Another would be mortality rates; there either was a mortality or there wasn't."

In setting up your equation, the numerator is a subset of the denominator, so the count is limited by the number of units inspected, Hart continues. "This is governed by the binomial [two names] distribution, and the data are kept on a p chart."

Referring to Hart's decision tree, "P," which stands for proportion, equals the number of items that have the attribute. "N" equals the total number in the P chart.

If the number of units inspected always is the same, it may be kept on an np chart, she adds. "This happens so rarely, however; and since the p chart will always work with this type of data, it may not be worth learning the np chart."

In the U chart, counts per unit are measured, and "C" stands for count. "Say we were looking at all the lab orders each week and wondering how many errors are observed; this would be plotted on a U chart," Homa-Lowry says, "because you can have a different number [of lab orders] each week. If there were 100 lab orders every week and you wanted to know how many errors were observed, you would use a C chart."

The second category of attribute data plots the number of occurrences, but the numerator (count of occurrences) and the denominator (area of opportunity) measure different things. The count is not limited by the area of opportunity. "This is governed by the Poisson distribution [named for the man who discovered it]," Hart notes.

"It could depict the number of injuries, the number of chips in chocolate chip cookies, and so on, and is kept on a C chart if the area of opportunity is constant, and on a U chart if it is not," she explains.

An example, Hart says, would be the number of patient falls per patient day. "The count is the number of falls, and if there are 100 patients there one day, there theoretically could be more than 100 falls on that day. If the number of patients is constant (or at least relatively constant), a C chart could be kept just on the count of falls each day.

If the number of patients varies from day to day, the data kept on a U chart are the number of falls divided by the number of patient days, or the number of patients times the number of days studied.

"You can't have some falls that were *not* falls," Hart explains. "You can't count how many times somebody *didn't* fall."

Whatever it is you decide to depict, and whatever chart is most appropriate to use, Homa-Lowry offers these words of warning before you even begin: "Make sure you have an operational definition for what you are doing — what it is you are going to collect, how you are going to collect it, the reasons for collecting it, and how you're planning to use the data," she says.

"If you don't do that, you may go through this whole process and have something you can't use," Homa-Lowry adds. ■

Control Chart Resources

For more information on using control charts, check out these resources:

- **Shewhart W. *Economic Control of Quality of Manufactured Product***, Van Nostrand; 1931. (Available at www.amazon.com.) Walter Shewhart, a statistician at the Hawthorne plant at Western Electric, authored what is considered to be the foundation of modern statistical process control (SPC), and provides the basis for the philosophy of total quality management or continuous process improvement for improving processes.
- **SkyMark**, Pittsburgh. Web: www.skymark.com. SkyMark offers two software packages: PathMaker for Windows and ipathmaker for the web. Both applications make it very easy for nonexpert users to make correct control charts and many other commonly used charts. They offer the main chart types, all the standard control tests, and auto-calculate all the relevant statistics. Both packages also include a full set of charting tools, plus brainstorm, affinity, flowchart, cause-and-effect diagram, voting, meetings, and more.
- **PQ Systems Inc.**, 10468 Miamisburg-Springboro Road, Miamisburg, OH 45342. Phone: (800) 777-3020. PQ offers software services to help its customers meet ISO and other standards to help them compete for the Baldrige Award and pursue Six Sigma efforts to improve quality. The company also provides training for SPC, measurement systems analysis, and quality improvement.

AMBULATORY CARE

QUARTERLY

ED is hotbed for lawsuits; address risky conditions

Most claims result from what you didn't do

What happens in your emergency department (ED) when a patient shows up complaining that he still has that terrible headache you sent him home with six hours ago? Do staff label him a whiner and send him back out the door with some Tylenol?

If so, you probably just created a lawsuit. You might as well call him a taxi and send him straight to a plaintiff's attorney.

That is only one of the most common situations leading to ED malpractice cases. The very nature of the ED, with patients arriving with unknown conditions and staff pressed to act quickly, is a recipe for disaster, say legal experts. Malpractice lawsuits are almost certain to happen, but you can reduce your chance of being sued significantly by paying more attention to the top five issues that are likely to take you to court, they say.

The ED is the source for a disproportionate number of malpractice claims at most hospitals, with about 20% of all of the hospital's claims originating there, says **Diane M. Sixsmith**, MD, MPH, FACEP, chairman of emergency medicine at New York Hospital Medical Center of Queens in Flushing.

In addition to her extensive ED experience, Sixsmith has been an expert witness and malpractice consultant for 25 years. She spoke on the topic at the recent meeting of the American Society for Healthcare Risk Management (ASHRM) in Nashville, TN, along with **Andrew S. Kaufman**, JD, a partner with Kaufman Borgeest & Ryan in New York City, a prominent law firm defending health care malpractice claims.

"You can't make your ED litigation-proof," Sixsmith says. "But most EDs could make themselves less of a target."

Sixsmith and Kaufman point out that when patients sue after being treated in the ED, they

often are motivated not so much by the actual care received but by how they felt they were treated personally.¹ That is especially true after an adverse event.

Even if the clinical care actually was subpar in some way, patients will be more likely to forgive that error if they perceive the ED staff as caring and attentive. But in the typically overcrowded ED, personal niceties often become a lesser priority. That atmosphere puts you at more risk of being sued, Sixsmith adds, but it also may increase the risk of actually providing substandard care.

"My theory is that the physician/patient and nurse/patient relationship is very much a part of health care. A bad relationship actually interferes with care." For example, not getting a good history or not talking to the patient enough to get good information affects the actual care, not just the perception of care, Sixsmith says. "If you're unpleasant with the patient, the patient won't be forthcoming with the information you need to provide optimal care," she explains.

Because ED physicians and staff start at a distinct disadvantage when it comes to avoiding liability, Kaufman says it is important to concentrate on those patients and situations that put you most at risk. For example, 90% of ED malpractice claims involve discharged patients, not those who were admitted for further treatment, he says.

Take action: Just do it

Sixsmith agrees and says most ED malpractice claims stem from what physicians and staff *didn't* do, not the treatment they provided. Even though Sixsmith acknowledges that emergency physicians and nurses should not do unnecessary tests and procedures, she does recommend that "action is better than no action. My mantra in the ED is, 'if you think of it, do it.'"

When deciding where to focus your risk-reduction efforts, Sixsmith and Kaufman point to these conditions as the most likely to lead to malpractice lawsuits in the ED:

1. chest pain;
2. headache;
3. abdominal pain;
4. head injury;
5. stroke.

Those conditions are the most risky because they can present in difficult ways, and it is easy for busy ED staff to overlook crucial signs.

Reducing your liability risk requires a concerted effort, Sixsmith says. It's not good enough to just urge everyone to practice good medicine and then hope for the best. You must take very specific steps that address the known hazards.

Sixsmith and Kaufman suggest taking these actions:

- **Focus more on customer service.**

Though this might seem like an unreasonable demand for overworked staff, it is crucial if you are to avoid lawsuits. When people walk away unhappy, they are far more likely to sue over any perceived wrongdoing in the ED.

- **Make sure ED physicians have the authority to admit patients to the hospital when they see fit.**

Lawsuits occur when the ED physician can't convince the doctor in another unit, a hospitalist, or the patient's private physician to admit and the patient is discharged. In many cases, the record shows that the emergency physician thought the patient should be admitted but then discharged him or her. Work with hospital administrators and medical staff leadership to give ED physicians the authority to admit a patient in such situations, Kaufman says.

- **Improve change-of-shift continuity.**

Many problems arise when patients are handed off from one physician or nurse to another at the change of shift, he says. Kaufman recommends a policy requiring the incoming shift to evaluate the patient as a new patient.

Never allow staff or physicians to rely on a general statement of the patient's condition from the outgoing shift. Patients are at great risk if the incoming shift assumes the patient is stable because the outgoing shift didn't say otherwise or the patient's condition changed.

- **Examine the patient twice as carefully on the second visit.**

ED staff *always* must pull the patient's chart from the previous visit to review it for condition insights, oversights, and in light of the patient's current condition, Kaufman says.

Sixsmith says a return visit to the ED is a pivotal moment, in which you can protect the patient

and save yourself or make things much worse. When a patient returns to the ED, "he's giving you a chance to right your wrong," she says. "And juries have no sympathy when you turn them out on the street again."

- **Evaluate the patient thoroughly even if you consult the patient's primary care physician.**

The malpractice liability rests with the ED and hospital while the person is your patient, Kaufman says. That doesn't change because of anything the primary care physician says over the phone.

"Either the primary care physician comes in and takes responsibility for the patient, or you evaluate that patient as if he had no doctor at all," he says. "You can't forego anything just because you talked to the patient's doctor."

- **Get the patient's family involved with decisions to leave against medical advice.**

"The family [members] will be the ones suing you if he dies," Kaufman adds. "They need to know that you tried your best to get him to stay for treatment."

Enlist the family to try to persuade the patient to stay for treatment, he advises. Explain to the family that the patient needs to stay, and ask for their help. Even if they are unsuccessful in preventing the departure, they will see for themselves that you did your best to convince the patient and did not just let him or her leave because you didn't care.

- **Provide more specific discharge instructions about when to return.**

Discharge instructions often don't say anything about the patient returning because symptoms remain the same. For some serious conditions requiring emergency care, the symptoms may remain exactly the same until the patient suddenly dies, Kaufman says.

He suggests that discharge forms include two boxes for the physician to check, depending on the circumstances. One can say, "Return to ED if you feel worse," and the other can say, "Return to ED if you don't feel better," Kaufman adds.

"I've had cases where the patient was discharged and had a bad outcome and then said he didn't return to the ED because they didn't tell him to," he notes. "The doctor told him to return if he felt worse, but the patient says, 'I didn't feel worse. I just didn't feel better.'"

Reference

1. Vincent C, Young M, Phillips A. Why do people sue doctors? A study of patients and relatives taking legal action. *Lancet* 1994; 343:1,609-1,613. ■

(Continued from page 38)

day-to-day utilization review," she says.

In the small rural hospitals, case managers coordinate the care of patients who frequently use the ED.

Covenant Health Systems has two different case management job descriptions:

- **Case Manager I** requires a bachelor's degree in nursing.
- **Case Manager II** requires a bachelor's degree and certified case manager (CCM) certification and earns significantly higher pay than Case Manager I.

All case managers, even those who have worked for Covenant Health for years, are required to get their BSN and their CCM within three years. ■

Integrated CM system will make your job easier

Tracking outcomes essential in today's climate

If your hospital isn't using case management software that is integrated with the rest of the hospital's information systems, you may be behind the curve, asserts **Vicky Mahn-DiNicola**, RN, MS, vice president of ACS Healthcare Solutions, a Tucson, AZ-based health care technology firm.

She calls case management "the glue that holds it all together" but adds, "people often question what case managers do because it's an interdisciplinary profession with what is often a nebulous role."

That's why it's important to be able to come up with data that demonstrate how case managers contribute to the outcomes of their populations, Mahn-DiNicola says.

"Case managers' jobs depend on their ability to tell those qualitative and quantitative stories to stakeholders. They have to be accountable for justifying their positions in terms of quality of care and financial efficiency," she explains.

In her dealings with hospital case management departments, Mahn-DiNicola has found that about 40% of case managers are savvy users of case management software and applications.

The rest are using paper-based systems or stand-alone homegrown systems that don't interface with their hospital's health information systems.

"It's amazing how many departments are using

homegrown tools they've created with off-the-shelf software. Unless these systems talk to other systems in the hospital and do so in real time, case managers may be spending unnecessary time searching for information or entering data into their systems. Case management departments that are run on information islands are not likely to be as productive or as valuable to their organizations," she adds.

For instance, if a diabetic patient is admitted to the hospital and case management is going to follow him or her, the case manager likely would have to enter the patient's demographic information into the case management system and consult a totally different information system to view medical history, laboratory data, or insurance information.

"This is just one illustration of how systems that are not integrated create nonvalue-added work," Mahn-DiNicola says.

In a system where the case management department's software is integrated with the hospital's legacy system, the administrative discharge transfer (ADT) and the discharge abstract system (DAB), the systems are interfaced so that much of the information case managers need to manage their patients already is available to them without duplication or redundancy.

"As care management systems become more sophisticated, they are beginning to interface with other parts of the medical record such as pharmacy data, laboratory data, imaging, and order entry. Not all case management systems are doing this yet, but case management departments that want to stay in the game are at least exploring these possibilities," she adds.

Case managers should be involved in the selection process of a vendor for any information system they will use, Mahn-DiNicola advises.

That means doing a lot of groundwork to prepare yourself for the selection process. To determine what you need to get from a new computer system, you must understand how patients and information move through your hospital's systems and what data already are being tracked, she says.

For instance, if your quality improvement department has software, learn all you can about the information it is collecting so this information can be leveraged to identify high-risk clients or evaluate case management outcomes.

"If possible, case managers should spend at least a full day shadowing a nurse who reviews records for purposes of quality improvement. It

is the best way I know to build a mutual understanding and appreciation for the contribution of another's roles," Mahn-DiNicola says.

Case managers should create opportunities to shadow inpatients and same-day surgery patients through the admission process so they can experience firsthand the information flow through the patient's eyes.

"It's amazing how many times patients are asked the same question between the time they walk into the admissions department and the time they are admitted to the nursing unit. Experiencing this firsthand will help case managers be better advocates for patients when they choose their information systems," she adds.

Here are some other suggestions that can prepare case managers to be savvy information system users and help choose a system that will meet their needs:

- Spend at least half a day with a medical records coder going over how the charts are processed and how DRG and ICD-9 diagnostic and procedure codes are generated.
- Visit the specialty nursing departments such as emergency, critical care, surgery, labor and delivery, and the cardiac catheterization lab to find out what information they collect and store.
- Schedule a meeting with someone in the cost accounting or finance department to learn how hospital bills are generated and how revenues and costs are managed.
- Meet with the directors of physical therapy, laboratory, blood bank, radiology, and other ancillary departments to understand what types of information systems they use and how this information is or is not linked to the main hospital information system.

"Once case managers have a bird's eye view of how patients and information move across the continuum of care in their hospital system, they are better positioned to identify what information needs they still have. This is important because you can't expect to get budget dollars for a case management system if you're not clear on how the various information systems will work together without duplication or redundancy," Mahn-DiNicola explains.

- Spend some time setting your goals. Begin by listing everything you would like to get out of your case management system each day, she advises.

For instance, do you want a list of everybody who came through the emergency department (ED) last night or all patient who have been in the

CE questions

9. The care designs at Covenant Health System, based in Knoxville, TN, include the core quality measures tracked by which organizations?
 - A. the Joint Commission and the National Association for Healthcare Quality
 - B. National Committee for Quality Assurance and the Foundation for Accountability
 - C. National Hospital Reporting Initiative of the Centers for Medicare & Medicaid Services and the Joint Commission
 - D. all of the above
10. According to Vicky Mahn-DiNicola, RN, MS, vice president of ACS Healthcare Solutions in Tucson, AZ, what percentage of case managers are savvy users of case management software and applications?
 - A. 70%
 - B. 60%
 - C. 50%
 - D. 40%
11. According to Diane M. Sixsmith, MD, MPH, FACEP, chairman of emergency medicine at New York Hospital Medical Center of Queens, why is customer service so important in reducing malpractice claims involving the ED?
 - A. People are more likely to sue when they feel the staff didn't care about them.
 - B. Most state laws cite customer service as a cause of action.
 - C. It is easier to prove poor customer service than to prove poor clinical care.
 - D. Good customer service is required by medical ethics.
12. According to Andrew S. Kaufman, JD, a partner with Kaufman Borgeest & Ryan in New York City, a prominent law firm defending health care malpractice claims, 90% of ED malpractice claims involve which patients?
 - A. admitted patients
 - B. discharged patients
 - C. cardiology patients
 - D. pediatric patients

Answer key: 9. C; 10. D; 11. A; 12. B

intensive care unit (ICU) for five days?

"There are countless different combinations of things that case managers want the case management system to do for them," Mahn-DiNicola points out.

As you start to come up with what you want in your system, keep your department's future plans in mind so you won't outgrow your system as soon as you implement it. If your hospital-based case management program has a vision to expand beyond the hospital walls, take this into consideration when you choose a software system. Make sure what you purchase now will meet your needs in a few years.

Mahn-DiNicola suggests developing a project team with representatives from each point of care in the continuum.

Typically, the information system department will take the lead on this type of project. The team should include representatives from quality management, utilization management, the medical staff, finance department, social work, and case management.

Once the software team gets together, the educational process begins. The information technology people must teach the members of the case management team basic principals of information management. Case managers should be able to articulate their workflow processes and other information needs so the team can support them in selecting the right product.

Everybody needs to be knowledgeable about the hospital's information management policies and procedures and the Health Insurance Portability and Accountability Act.

The first step in identifying software vendors is to create a request for information, a document that explains broadly to a variety of vendors what the organization is seeking. It should include information on the hospital's mission, number of beds, and how the software will be used.

The purpose of a request for information is not to choose a vendor but to weed out vendors who can't meet your needs.

"At this stage of the game, you should not expect a quote or detailed product specification, although you might receive a list of clients from organizations similar to your own," she says.

Typically, hospitals send out a dozen or more requests for information and narrow the selection down to a few vendors who are invited to submit more detailed proposals.

After you have identified a short list of vendors, the next step is to create a formal request for proposal (RFP) document, typically a collaborative effort between the information systems department and the stakeholders.

The RFP is a very detailed document that identifies specific case management processes and other details about how the system will be used. Include information about your hospital's technology infrastructure.

For instance, if your system has eight hospitals all connected by a wide-area network, you'd have different needs than those of a 32-hospital system in a nationwide chain with no connectivity.

The RFP should include a case management scenario to be used in demonstrating how the system works and an evaluation tool that you will use to evaluate all vendors.

To create the demonstration scenario, Mahn-DiNicola suggests thinking of the most challenging case management scenario you handle so you can see the full potential of the vendor's system and identify any problems you will encounter.

For instance, a patient comes into the ED after an accident and is admitted to the ICU. How can the case manager find out quickly that the patient was in the health care system several months previously being treated for diabetes?

How does the case manager who has been coordinating the diabetes care find out that the patient has been readmitted for the trauma?

"The case managers should weave the story so you involve all the things they have to deal with during the day," Mahn-DiNicola says.

If your case managers handle insurance authorization, utilization review, or discharge planning, build that into the scenario.

Ask how the case manager would find an agency that matches a payer's approved list of services or get a summary of a patient's benefits.

Ask for a demonstration of how reports, letters, or tickler files are generated.

Work with the vendors to design the system.

"Vendors work collaboratively with a lot of different case management models and a lot of different ways of managing care," she says.

Make sure that the system you choose can be

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customized to meet your particular needs.

The case management director and staff should be involved in establishing what the software should do, such as what kind of reports will be generated and what kind of data you will put in and get out.

"You should think about what the end product will be like," Mahn-DiNicola says.

The software will be different depending on your case management models. Some are organized by nursing unit, others by product line or service line.

"Every hospital has its own little twist on how they do things. It's critical for case management software to be flexible in the marketplace because one hospital case management department might have different goals from another," she says.

Mahn-DiNicola recommends that designated staff be assigned to maintain and support the system once it's in place. The information systems staff will be heavily involved while the system is being installed, but then they tend to back off and leave the system management in the hands of case managers, she says.

Budget funds to train the staff who will be responsible for stewarding the system.

"When you have case managers who are information-savvy, you have empowered your department with the tools needed to make a big impact on care in your organization. Having one or two case managers who can run reports, explore trends in performance data, and synthesize clinical information is really the new frontier for case managers. It's an exciting role for nurse case managers to explore," she says. ■

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. ■

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