HOSPITAL CASE MANAGEMENT™

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

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Hospitalists and case managers team up for better outcomes

Trend toward inpatient specialists is on the rise

When Christiana Hospital in Newark, DE, first instituted its hospitalist program in 1994, the hospital experienced a big drop in length of stay, especially with the uninsured patients who had no particular physician watching over them, recalls **Thomas Mannis**, MD, senior medical advisor for case management and head of the division of hospitalists. "We have been very happy they are here. It's nice to have a group of doctors you know and can turn to. Hospitalists increase the hospital's efficiency because they can make rounds more than once a day and they're available to come back and discharge patients," he adds.

If your hospital doesn't already have a hospitalist program, there could be one in the works in the near future, experts say. In particular, more large hospitals are turning to hospitalists to provide care for inpatients, improve timely discharges, and ultimately affect the hospital's bottom line.

Hospitalists are physicians who only take care of medical inpatients. They don't have an office practice but only see patients in the hospitals.

When a hospitalist and a case manager work together as a team, the two of them can carry a bigger patient load than both can alone, says **George Martin**, MD, team leader for VHA Inc., an Irving, TX-based health care cooperative.

The most effective programs at VHA's member hospitals create a close working relationship in which the hospitalist writes the medical treatment plan and the care manager makes sure it is carried out appropriately and in a timely fashion.

A hospitalist alone can care for about a dozen patients, Martin says. A case manager can carry a caseload of 15 to 20 patients. "Put the two together and the hospitalist, with the assistance of the case manager, can cover 18 or 19 patients. Because the case manager can easily reach the hospitalist when necessary, she can carry a load of 24 to 28 patients a day."

"This is a big deal in terms of efficiency and cost savings," he adds. In one successful hospitalist model, case managers work with a hospitalist to manage about 18 medical patients and also manage the care of six to eight surgical patients who are not the responsibility of the hospitalists and typically require less coordination of care than a medical patient, Martin says.

Hospitalists focus on inpatient care. Because they're on-site, they see patients more quickly and move them through the continuum efficiently, points out **Beverly Cunningham**, MS, RN, director of case management at Medical City Dallas Hospital.

"Hospitalists make a lot of sense from a financial standpoint, from a quality of care standpoint, and from a patient satisfaction standpoint," Martin adds. For instance, instead of having 200 internists who admit several patients a month, there are six or seven hospitalists who admit the majority of the medical inpatients.

Case management staff find it easier to get a response to questions, implement standardization of care initiatives, measure care, and determine accountability for glitches in the system.

It's much easier to provide feedback to six or seven hospitalists than to 200 internists, adds Cunningham. "It's easier to develop a relationship with hospitalists than other physicians. They are constantly in the hospital as opposed to being in and out like other doctors," she says.

At Cunningham's hospital, many of the large multispecialty groups refer their hospitalized patients to hospitalists. Having hospitalists in the hospital at all times speeds up the discharge process and improves patient care, she says. "The hospitalists move the patients in and out of the hospital. These days, that's not just decreasing costs, but it's also freeing up beds."

Christiana Hospital has two hospitalist groups for adult medicine and a small pediatric hospitalist group, Mannis says. The two groups are independently owned and tied into the hospital under contractual standards. The hospitalists at Christiana Hospital provide care for about 65% of the medical patients and 20% of all patients.

The program was started when a group of hospitalists approached the hospital in 1994. "Patients in the hospital are sicker and sicker. Family practitioners and general internists don't always feel comfortable treating them. They started handing off care on weekends and at nights," Mannis says.

The hospital has a division of hospitalist medicine, headed by Mannis, who meets with the hospitalists regularly, gives them data, and talks to them about any problems that have been identified.

The hospital changed its case management model in March 2004 to a unit-based model. At present, each hospitalist cares for patients who

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are scattered all over the hospital. The hospital is working with the hospitalist groups to persuade them to be unit-based so the hospitalists and care managers will be in contact all day long, Mannis says.

In the previous model, the utilization nurses were unit- and product-based, the case managers were unit-based, and the social workers were not assigned to a particular unit. "This arrangement worked well, but it didn't meet all our needs. We wanted someone on the unit to drive the performance indicator issues," he says.

Under the new model, the case managers are called care managers and are assigned by unit.

The care manager does the initial case management assessment, identifies who is ready for discharge, and handles discharge planning. The care manager guides the patients through the process of choosing home health vendors.

The care managers make rounds every day with the charge nurse and the primary care physician, looking at the Joint Commission on Accreditation of Healthcare Organizations and Centers for Medicare & Medicaid Services indicators.

The length of stay at Christiana Hospital has been creeping up lately, he says, possibly because

Keep hospitalists on the right track with proper Incentives

Work closely with hospitalists from the first day

At Medical City Dallas Hospital, there is a "healthy competition" between two hospitalist groups who compare their outcomes with those of the other group and all the physicians in the hospital, says **Beverly Cunningham**, MS, RN, director of case management.

The hospital's outcomes studies include length of stay (LOS), case-mix index, cost per case, and compliance with the Joint Commission on Accreditation of Health Care Organizations' (JCAHO) core measures for congestive heart failure and pneumonia.

The case-mix index is an important part of the outcomes studies, Cunningham says.

For instance, when Cunningham studied only LOS, she found that one group of hospitalists had a longer average LOS but had a higher case mix than any others. When the case mix was factored in, the group was getting better outcomes than any other medical practice.

Christiana Hospital in Newark, DE, generates a report card for its hospitalist groups each month covering items such as average LOS, cost per case, number of consults, commercial insurance denials, number of nonacute days, compliance with the 11 a.m. discharge time, and other factors, says **Thomas Mannis**, MD, senior medical advisor to case management and head of the division of hospitalists.

The hospital looks at the hospitalists' top DRGs, their LOS vs. Centers for Medicare & Medicaid (CMS) averages, and any other benchmarks to give them an idea where they stand. Under the new care management model, the hospital will generate report cards for the unit including LOS, cost per case, and compliance with JCAHO, CMS, and other indicators. "Hopefully, the care manager and hospitalists will review the data with the nurse, and it will work out very well," he says.

Many hospitals include incentives in the contract when they employ hospitalists. "They need to know what's in it for them. We have talked about this because we don't have incentives tied into the practice," she says.

When a hospitalist is not employed by the hospital, the financial incentives require a little more thought. Some hospitals base the number of days the hospitalists work in the emergency department (ED) on their outcomes.

"This is a great idea. The better the outcomes, the more emergency department calls they get, and the more calls they get, the more patients they'll have," Cunningham says. At Medical City Dallas Hospital, hospitalists get referrals from the ED and from physicians in the community.

It's in the hospitalists' best interest to move patients through the hospital quickly and free up beds for new patients, Cunningham points out.

"If the hospital is full, they can't accept referrals because we have no beds. This cuts into their referral base," she says.

Here are some other tips for more effectively working with hospitalists:

- Set up the program in such a way that the hospitalists are not overburdened and overworked.
- Make sure there are a minimum of three hospitalists, preferable four or more, in a group so they can provide care at the hospital every day and rotate the night coverage.
- Promote continuity of care for patients by avoiding having hospitalists care for all the patients they admit, rather than working a particular shift and going home.
- Work closely with the hospitalists from their first day on the job and create a close relationship with them so they realize the value of working with case managers.
- Develop a forum to address delays the hospitalists experience. This could be in the form of a hospitalist or inpatient physician committee that discusses issues related to the hospitalist program. ■

the hospital's case mix includes more acutely ill patients. "It's hard to compare. So much has changed in hospital medicine since the program," Mannis says.

Medical City Dallas has unit-based case management and social work with one social worker assigned to the two adult hospitalist groups, says Cunningham. "In the first year of the program, the hospitalists had their own case management, but once they understood medical necessity, we switched to unit-base social work and case management." If there isn't a hospitalist, the attending physician makes rounds and writes orders but may not be back to the hospital to review the results until the evening or the next day. This delayed follow-up by the admitting physician sometimes increases the patient's length of stay, she explains.

Anytime an intervention is ordered, whether it's a test or a procedure, the hospitalist is right there and can monitor the progression of the order. For instance, a radiologist may call the attending physician at his or her office if there is a question, but it may be hours before the physician can return the call, leading to a delay in testing and a delay in discharge.

The hospitalists see the patients in the morning, check on the tests later in the day, and may make several interventions during the day. If the test results show the patient is ready for discharge in the afternoon, the hospitalist can issue the discharge orders. "It's not easy for a physician who is not hospital-based to do this when they are providing an office practice at the same time," Cunningham says.

Referring their hospitalized patients to a hospitalist for care is advantageous for family practice physicians, internists, and pediatricians, Martin points out. A typical general practice physician may have only two or three patients in the hospital at one time. Driving to the hospital, finding parking, seeing the patients, and driving back to the office can take an hour or two. "It doesn't add to the bottom line either in time basis or dollar basis," he explains.

With a hospitalist, patients should have short lengths of stay, lower costs, and should be able to move through the health care system more quickly, Cunningham notes.

With an average cost of about $500 a day, discharging patients on time represents a tremendous savings, Martin adds. At the same time, if a patient takes a turn for the worse, the hospitalist is on the premises and can evaluate his or her condition and start treatment immediately, he says.

Because of the nature of their jobs, hospitalists become inpatient disease specialists and are very familiar with the inpatient disease processes, whereas a primary care physician may have only a general knowledge of some diseases that require hospitalization, Cunningham points out.

Hospitalists may be employed by the hospital or be in an independent practice that is affiliated with the hospital through an arrangement similar to those for ancillary physicians such as radiologists and emergency department physicians. But unlike those physicians, who have mainly ancillary functions, hospitalists provide direct patient care in the hospital setting.

Some physician groups set up a rotation of office physicians who take turns being the hospitalist. For instance, they may be out of the office and in the hospital once every eight weeks.

Hospitalists oversee the comprehensive care of the inpatient. The patient typically has an internist or family practice physician but needs inpatient care. Patients are referred for admission by the internist or a surgeon, especially if they are medically complex patients having a surgical procedure.

Hospitalists most frequently are found in larger hospitals. A hospital 350 beds or smaller may not have enough patients to support three or four hospitalists, the minimum necessary to cover the hospital 24 hours a day, Martin says. About 10% of VHA's member hospitals have a hospitalist program, and an additional 25% to 30% are considering setting one up, he adds.

Burnout can be a problem

While hospitalists can be effective and efficient, the programs don't always work to everyone's satisfaction. Burnout from long periods of time on call is one problem cited by Cunningham and Martin.

One big drawbacks with hospitalists is that many patients have gone to the same family practitioner for years and want their familiar physician to take care of them in the hospital. "They're being seen in the hospital by a doctor they don't know at all, and there is always that potential patient satisfaction issue," Cunningham says.

A hospitalist program works best if the hospitalists are in independent practice, as opposed to being employed by the hospital, Martin states. Hospitalists employed by the hospital typically work in shifts like emergency department physicians, leaving the patient without continuity of care, he adds. ■

Six Sigma improves care, reduces hospitals' costs

Projects reduce variation, create efficiency

Before Virtua Health instituted a Six Sigma project to improve its congestive heart failure program, the hospital system's average length of stay (LOS) was 6.5 days, compared with the Medicare benchmark of 4.2 days. After a pilot project at one of the Marlton, NJ-based nonprofit health care provider's four hospitals, the LOS dropped to four days with a savings of $116,000 per year in staff and room costs.

Virtua Health has improved patient care and generated literally millions of dollars of savings in its four hospitals by using Six Sigma, a strategic problem-solving approach to improving business operations. "If hospitals don't consider ourselves a business, we're going to be in trouble. With reimbursement declining, the only thing we can look to improve is the processes," says **Richard P. Miller**, president and CEO.

Six Sigma was developed by Motorola and has been used by industry to improve processes for years. General Electric has developed a Six Sigma program specifically for health care professionals.

In the congestive heart failure project, the Six Sigma team examined the processes and found a lot of variations in what happened during the latter part of the patients' hospital stays and during the discharge program.

For instance, about a third of the time, echocardiograms were not on the chart when the physicians needed them. Patients and their family members generally expected a longer LOS, and the family members often weren't prepared to take the patient home on the day of discharge. "We began by making the patients and family aware on Day 1 of the activities that would take place during the hospital stay and the likely length of stay," Miller says.

Telling people their family member is likely to be ready for discharge on the third day helps them plan ahead for taking the patient home, he adds.

The team created a brochure for patients, which explained the typical course of care for congestive heart failure patients and the expected LOS. It modified the flow of test results and created standard operating procedures for the nursing team.

The pilot project was conducted in one of Virtua's four hospitals and has been rolled out at the other facilities. "The congestive heart failure project looked at all the processes from beginning to end and really streamlined what was happening, incorporating patient and family education into the process," Miller says.

As a result, more beds were free and revenue was enhanced, he adds.

Six Sigma looks at the processes in health care and reduces the variation, cuts the number of steps, and allows the provider to get to its goals quicker and more efficiently, Miller says.

"The mindset in health care has been that improving quality will cost more. In a typical manufacturing setting, an improvement in quality means lower cost. We have found that if we take the variation and fragmentation out of health care, it will result in a lower cost and better patient care," he adds.

Miller brought the Six Sigma process to Virtua Health in 2000 to support his STAR initiative, a five-pronged program to improve the patient experience. Components of the STAR are excellent services, employee satisfaction, clinical quality, caring culture, and resource stewardship. "I see Six Sigma as being a valuable part of a toolkit to improve patient care," he notes.

The hospital system has embarked on 40 major Six Sigma projects, creating upward of $2 million in annual savings, explains **Mark VanKooy**, MD, a Virtua Master Black Belt who oversees six full-time team project leaders along with **Susan McGann**, RN.

In the second year, the Six Sigma projects generated enough savings to pay for the original cost. Now, savings are running two to three times the annual cost.

Six Sigma is not necessarily a quality tool. It's a business tool, and quality is one important part, VanKooy points out. For instance, one project involved improving reimbursements for carve-outs for implantable prosthetic devices in managed care contracts.

"The processes were breaking down. We weren't capturing the new implantable devices and were not collecting from the insurance company," Miller says. As a result of the Six Sigma project, the hospital system was able to recapture close to $4 million the first year. "It had a huge financial impact," he says.

When the hospital considers a Six Sigma project, VanKooy and McGann look at all the stakeholders who will be touched by the project and decide how much each needs to be involved. Some may need just information; others need to

be a member of the team because they are knowledgeable about the process. Still others may be called in as a resource only when they are needed. Case managers are part of the team in many projects, particularly those involving outcome improvement and moving patients through the continuum.

One part of the Six Sigma toolkit, called workout, encourages the team members to examine what caused processes to fail and to come up with steps to prepare for change ahead of time so initiatives will succeed. The exercise is followed by a one- or two-day brainstorming session that concludes with the development of action sets. Teams look at operational systems and discuss the reasons that problems occur. Then they focus on the biggest problems and what should be done about them. When the session is over, the team has developed an action plan to be implemented.

"It is action-oriented consensus building. One of the reasons it works is that in most meetings we spend 80% of the time discussing what we already agree on. This way, we understand why we disagree and come up with an action plan," VanKooy says.

A Six Sigma project is broken into five components: define, measure, analyze, improve, and control. Start by defining a process to improve, then measure how problems occur. Coming up with a valid measurement is a process that often takes a lot of work, he adds.

"Measuring systems in health care are often very weak. The most important thing is coming up with a gauging activity to see how well your systems measure," he explains. For instance, in one Six Sigma project, the leaders had the case managers review a set of charts to determine whether medications were given on time and whether any contraindications were noted.

The case managers agreed as little as 35% of the time. "We had reviewed the charts in advance and knew the answers. We determined that some of the information we were reporting to the Center for Medicare & Medicaid Services [CMS] which was ending up on the Internet as a reflection of our quality was inaccurate because of data collection errors and understated our actual performance, VanKooy says.

When the Six Sigma team met with the case managers to discuss the problem, it found the case managers never had been trained on how o gather the information needed for the CMS reports. They were given forms and told how to do it but weren't told how to interpret ambiguous situations. When they worked on the problem, their agreement went to 85% to 90%.

"Once we fixed the measurement process, we determined that we had two serious problems: documentation of contraindication and when the proper medication is not administered or not prescribed," VanKooy says.

The team then started to look at why the problem occurred and who was accountable. It determined that a significant number of patients who were hospitalized for a myocardial infarction (MI) were not receiving aspirin within 24 hours as recommended.

Patients with an obvious MI got aspirin right at the beginning. It was the patients with the subtle symptoms who didn't get the aspirin because their heart attack wasn't diagnosed until the test results were complete, and they often missed the cutoff time established by CMS, VanKooy says.

The solution to the problem was totally unexpected, he adds.

The team looked at patient records and determined that most patients with an MI who didn't get aspirin had shortness of breath. The team recommended that the paramedics give one aspirin to all patients with shortness of breath when it is clinically safe to do so. For instance, patients with asthma wouldn't get an aspirin.

"We made sure we mistake-proofed it. It was a very successful intervention, and one that we never would have thought of without following the Six Sigma process. Our compliance went way up when we implemented that one simple thing," VanKooy says. The final phase, the control phase, is extremely important to the success of a Six Sigma initiative. "Other than not defining the problems appropriately, the biggest problem is to make improvements and not stick to them."

In the control phase, to assure long-term success, the process owner uses a reduced set of metrics to monitor deviations from the plan. "When the process starts to backslide, they detect it very early, and they know what steps to take," he says.

Six Sigma works on complex problems where there are steps you can take and a way to measure the results. For instance, Virtua tried to apply Six Sigma techniques to improve employee retention. "There are no specific steps you can apply to this process. It's an important issue, but Six Sigma can't work for it. It's not for everything," VanKooy says.

(For more information on GE Healthcare's Six Sigma program, see: www.gehealthcare.com/prod_sol/ hcare/sixsigma/). ■

CRITICAL PATH NETWORK™

What to do if physicians dispute your data

How to present data effectively

It's a frequent tactic of physicians: claiming that quality data are imperfect, invalid, or otherwise misleading.

"When physicians are not acting on proven data, the quality manager has to stand up to the physicians and protect the integrity of the data," says **Frederick P. Meyerhoefer**, MD, principal of the Canton, OH-based Meyerhoefer Organization, a consulting firm that specializes in compliance with Joint Commission on Accreditation of Healthcare Organizations standards.

"Physicians forget that they make decisions daily about their patients with clinical data that are frequently imperfect," he adds.

If you're not able to analyze and present data effectively, physicians continually will challenge their validity, Meyerhoefer warns. "This will bog down the system with nitpicking rather than performing the needed analysis for patterns and trends and opportunities to improve," he says.

Here are effective tactics to use when physicians challenge your data:

- **Give key physicians a heads-up before meetings.**

It's a good idea to brief committee chairs in advance about data you'll be presenting at a meeting, Meyerhoefer advises. "It is also usually a good tactic to identify influential physicians and make them aware of the data and their import."

This way, physicians are aware of the implications of the data and you'll avoid blindsiding them, he explains, adding that you also should consider briefing naysayer physicians in advance to head off potential obstacles, he suggests.

- **Convince physicians to act on good data.**

Physicians may be reluctant to take action even when the data are beyond reproach, Meyerhoefer says. In this case, you'll want to avoid a full-blown confrontation, but you must urge physicians to act on the data, he advises.

For example, if data reveal that certain physicians are failing to discharge myocardial infarction patients on beta-blockers, intervention by the department chair and specific monitoring of the physicians might be called for. Or you might need to push physicians to implement a corrective action for the use of unapproved abbreviations and illegible handwriting monitoring.

If there is a physician with data with significant deviation from his or her peers, the presentation of that fact frequently is the only incentive needed to change behavior, Meyerhoefer notes. "No physician wants to be the sore thumb," he says.

You'll need to instruct physicians on moving to the next "drill down," even when data indicate that a goal has been reached, Meyerhoefer says. For example, if a goal for 90% compliance has been reached, physicians need to look intensively at the noncompliant 10% of the data to identify correctable factors.

"The quality manager must be the goad to move ahead for further quality improvement in patient care and decrease the 10% variance," he notes.

- **Be proactive if physicians lack confidence.**

"Physicians are very data-driven," says **Tania V. Bridgeman**, PhD, RN, director of clinical pathway development at University of California — Irvine. "If they get flawed data one time, it is a very long recovery period before they are comfortable again."

For example, a physician might ask for data on a certain procedure, but the wrong ICD-9 code is

queried. "Once they see something like that, their confidence level drops. So all your homework must be done with no bases left uncovered — they will find them."

If a physician contends that poor-quality data have been received from one of your team members, your instinct might be to downplay the individual in question to avoid conflict, but this is a mistake, Bridgeman says. Instead, she recommends bringing the person to individual meetings to regain confidence.

"If a physician doesn't believe in the integrity of data from finance or another hospitalwide clinical database because they've been burned in the past, I bring those key people in," she says. "You don't put them in the background — you place them out front."

For example, the facility's spine surgeon said he had received some flawed data from the decision-support analyst, so Bridgeman brought that person to a meeting with the physician so she could address the problem directly.

"Every time I went to meet with him, she became an integral part of the meeting. I didn't go away; I continued to return with this person to the same physician over and over again," she says. "It gradually built up the confidence level."

Bridgeman attributes this to having "relentless follow-through. If I said we were coming back with data in two weeks, we went back in two weeks and I gave the floor to the person they had some trepidation about," she says.

- **Identify physician champions.**

Enlist the help of individuals who strive for clinical excellence and are not afraid to address issues with other physicians, Bridgeman says. When she developed a clinical algorithm for abdominal pain, she sensed resistance from the entire emergency department (ED).

"They didn't want to follow a predetermined algorithm and also be asked to access an electronic order set that would activate the pathway," she recalls. "I took the physician champion with me. What I wasn't able to address as a nurse, he was able to address. Ultimately, the ED chief joined forces with the champion."

If problems occur with resistant physicians, the champion can help with that problem as well, Bridgeman says. "If you find that people are slacking off from using the pathway, then the champion would come in behind you and help with the reeducation process to achieve compliance," she says.

She says that the "physician champion" strategy has made quality projects a success several times at her facility. For example, it was determined pneumonia patients admitted through the ED sometimes were having blood cultures drawn after antibiotics were administered, instead of beforehand.

"This null and voids the blood culture," explains Bridgeman.

She used the facility's clinical documentation system to pull the records of 35 pneumonia patients and discovered that the problem was occurring 27% of the time.

The cause was due to a communication breakdown in the transfer between the ED and the inpatient nursing unit, says Bridgeman. "There was an assumption that antibiotics had not been given, when they actually had been given in the ED," she explains.

As a result, a systemwide educational process was implemented, with the champion physician and the chief of the department of medicine going to grand rounds to educate the residents. "We also educated all nursing units again on the importance of this," Bridgeman says.

Similarly, physician buy-in was integral when a quality issue arose regarding blood transfusions. "When we found the benchmark for blood transfusions was approximately 30% and we were at 60%, we initiated an action plan for an in-depth look at what was going on," she says. "The re-transfusion of autologous blood is pervasive across the United States."

In this case, Bridgeman worked with the physician champion to get the chief of the department of orthopedics and chief of pathology on board. A performance team met and determined that the facility's intraoperative cell saver required a pump technician to operate, who wasn't always available. "So we purchased a smaller machine that transfused both on the OR and the PAR [post-anesthesia recovery], and continued to transfuse on the unit," she says. The equipment collects up to 1,000 cc blood, which is cleansed and re-transfused. The autologous rate of transfusions now are dropping, in accordance with the national benchmark.

- **Ask physicians for input.**

Don't hesitate to ask physicians directly for their help, Bridgeman advises. "A plea for assistance enhances their credibility and thus elicits their support," she says.

Physician leaders typically have access to databases and a network of colleagues to consult with, and in turn, will offer the information to you, she says. When you appeal for physician

input, emphasize that your facility is comparing unfavorably with others, Bridgeman suggests. For example, say, "Look at where we stand against other university medical centers — we've got to change this.

"You have to tell them, 'I am really in trouble and can't get to the bottom of this. I need your help and expertise,'" she adds. "All of a sudden, they feel part of the process because you are asking for their help." ■

Physician buy-in helps PI team reduce LOS

Data credibility, physician champion key elements

Winning physician buy-in, one of the toughest challenges in any process improvement (PI) endeavor, was the key to success in a PI project undertaken by Peninsula Regional Medical Center in Salisbury, MD. The project, which targeted clinical PI in pneumonia, realized a reduction in average length of stay (LOS) from 5.7 days to five days between 2001 and 2003, along with significant drops in resource utilization.

"We try to build credibility with our physicians," notes **Thomas P. Lawrence**, MD, MBA, vice president for medical affairs and premier physician ambassador at the 370-bed regional tertiary care center that serves Maryland's Eastern Shore and nearby sections of Delaware and Virginia. "Most important of all, you have to be credible with your data."

Hospital data, in general, often have been incorrect, and physicians, therefore, are very suspicious, Lawrence observes. "Unfortunately, they are looking for perfection, which is almost unattainable," he notes.

To help address that resistance, Peninsula decided to use Premier Inc.'s Perspective clinical benchmarking database. Internet-accessible, Perspective has 525 hospitals enrolled to comprise its clinical resource comparative database.

"What Premier provided was believable enough, and by beginning to change the culture, we showed the physicians that we needed direction, not perfection," Lawrence says.

Peninsula's strategy for garnering physician support is three-pronged:

1. Engage physicians in dialogue.
2. Align their goals with the organization.
3. Celebrate and recognize their contributions.

The pneumonia initiative grew out of a tradition of improvement begun at Peninsula in the 1990s, adds **Donna Thompson**, RN, BSN, director for clinical quality improvement support.

"It began with the development of clinical pathways — the first one I recall was a med/surg hip clinical pathway," she says. "It was a multidiscipline team effort, and we developed a template for future pathways."

Peninsula began working with Premier a number of years ago. "When we saw the clinical comparative database Premier had, it was a natural for us to use for our quality improvement initiative because it was a robust database and we could benchmark ourselves to many other, similar organizations," Lawrence says.

Peninsula is a bit unique, he notes; it is a complex organization, but it is not a teaching institution, and yet it is rural. Still, it was able to get about a dozen other organizations within the database that were fairly similar.

"This made it easier for our physicians to see information that was relative to them," Lawrence points out.

"They were even similar in terms of volume of ED [emergency department] visits per year — and we have over 60,000," Thompson adds.

Peninsula presented the undertaking to the physicians as an education collaborative. "We explained we were not going to use the data in a punitive fashion," Lawrence says.

Once the benchmarks were identified, Perspective was used to conduct an opportunity assessment, which identified the greatest opportunity either by cost per case or by LOS.

"That's what led to pneumonia," he explains. "We could certainly come up with 10 or 20 clinical conditions [to benchmark], but we verified that there was a lot of low-hanging fruit in pneumonia, and it was a high-volume admitting diagnosis."

Peninsula already had a pneumonia pathway team in place, so with a few additions, it was ready to get to work. The process, which is a template now for all PI efforts, has six basic steps:

1. Forum.

To begin to get buy-in, you have to take the initiative to the medical staff leadership committee, to see if the staff would support it. In this case, it was the resource utilization committee.

2. Clinical opportunity assessment.

This involves winning staff agreement that this would be a good opportunity around which to form an initiative.

3. PI issues directed to ad hoc teams.

Once there is consensus, the initiative is sent to the appropriate team.

4. Ad hoc team action plan review.

The current pathway is reviewed, a gap analysis is conducted, and then the pathway is tweaked based on what has been learned.

5. Approved plan to pertinent department.

The team reviews the new plan, tweaks it some more, then goes back to the forum that initiated the process to ask them if the changes make sense. Then it's on to the department of medicine, where physicians are educated about the new plan and buy-in is gained.

6. Remeasure and review.

The results are checked, after which they are posted on a PI board and in clinically important units, so patients and employees in the units can see them.

The process involved several important changes. "We got together a group of physicians and redid the whole formulary, looking at the cost of drugs and evidence-based literature on drugs for non-ICU [intensive care unit] vs. ICU patients, and incorporated it into the doctor's actual order sheet, so there would be no guesswork," Thompson says. "We used a check box kind of format — the meds were right there with the dosage — which was more user-friendly for the physicians."

In addition, Joint Commission on Accreditation of Healthcare Organizations core measure indicators were incorporated on the order sheet to remind the physicians what they needed for the hospital to be compliant — i.e., blood cultures, antibiotics, oxygen assessments.

"We found we were spending significantly more money on respiratory therapy than in other places, and more on blood gases than on O_2 saturation," Lawrence says. "We adjusted our standard so that we were 100% compliant with the core measure and significantly reduced expenses on blood gases. Also, we were doing more PT than our benchmark group. That seemed to be more expensive; but when we checked the literature, we decided it was an appropriate expense and it has helped us with decreased LOS."

None of this could have been accomplished, Lawrence says, without physician buy-in. And a key element in winning that buy-in, he says, is having a physician champion. "Without that, it's a pretty tough sell. You need someone who's supportive, a good communicator, a good listener, and can talk about his or her peers."

If the end result you are looking for is to grow corn, says Lawrence, "a lot of tilling of the soil is needed." That starts with education of the medical staff leadership. "They need to know what it means in today's age to be a good physician," he explains.

At Peninsula, physicians receive leadership training from an outside consultant, as well as attend national meetings about quality, costs, and outcomes.

"Unless PI is linked to lot of hard work around medical staff development, it can be sitting out there as something you have limited success with," Lawrence asserts, adding that there is an economic incentive to quality today. "More payers are going to pay for performance," he says. "The good news is that this not only does not compromise care, but it improves it." ■

CE *questions*

This concludes this CE semester. Please fill out the enclosed CE evaluation form and return in the envelope provided.

21. At Christiana Hospital in Newark, DE, hospitalists provide care for about what percentage of the medical patients?
    A. 20%
    B. 47%
    C. 65%
    D. 100%

22. According to George Martin, MD, team leader for VHA Inc., in Irving, TX, a hospitalist program works best if the hospitalists are in independent practice.
    A. true
    B. false

23. Which of the following is not one of the five components of Six Sigma?
    A. define
    B. test
    C. analyze
    D. improve

24. Richard P. Miller, president and CEO of Marlton, NJ-based Virtua Health, brought Six Sigma to the organization in 2000 to support what initiative?
    A. Joint Commission survey readiness
    B. Malcolm Baldrige Award application process
    C. compliance with Leapfrog Group standards
    D. the STAR initiative

Answer key: 21. C; 22. A; 23. B; 24. D

AMBULATORY CARE
QUARTERLY

Pneumonia guidelines will affect 750,000 ED patients

Recommendations address antibiotics, lab, SARS

An adult patient with fever and cough: This is something you probably see at least once a day and perhaps dozens of times a day in your emergency department (ED) during the flu season. But did you know about new recommendations that call for changes concerning when patients receive antibiotics, which diagnostic tests they are given, and whether they are discharged or admitted?

Newly updated guidelines for community-acquired pneumonia from the Alexandria, VA-based Infectious Diseases Society of America (IDSA) will have a major impact on the 1 million patients admitted for pneumonia each year, 75% of which are admitted through the ED.[1] **(For information on how to access the guidelines, see box, p. 92.)**

"In our hospital, 90% of all adult admitted pneumonia cases come through the ED," says **Rosemary Kucewicz**, RN, BSN, ED manager at Northwest Community Hospital in Arlington Heights, IL.

Approximately 30 adult pneumonia patients come to the ED each month at Harborview Medical Center in Seattle, and that number increases to 40 or 50 per month between December and March, reports **Darlene Matsuoka**, RN, BSN, CEN, CCRN, clinical nurse educator for the ED.

To significantly improve care of pneumonia patients and comply with updated guidelines, make the following practice changes:

- **Customize use of antibiotics.**

Different antibiotics now are ordered for individual populations and circumstances, Matsuoka says. "By using the IDSA guidelines for pathogen-specific therapy and empiric therapy, the best antibiotic choices can be used for every patient."

The new guidelines recommend different antibiotics be used for healthy patients as opposed to those with comorbidities such as renal failure or aspiration pneumonia, Matsuoka says.

"We treat our patients with empiric antibiotics targeted to the specific site, treated as outpatient, in the nursing home, or admitted to the hospital, either to an intensive care unit or a regular nursing unit," says **Nina M. Fielden**, MSN, RN, CEN, an ED clinical nurse specialist at Cleveland Clinic Foundation. "Our hospital does not use fluoroquinolones unless necessary because of the concern for resistance to these drugs in our region."

The Pneumonia Outcomes Research Team Severity Index criteria are used to determine where patients should receive their treatment, she adds.

- **Order different tests for specific agents.**

Conventional tests such as blood cultures, sputum gram stain, and sputum culture and sensitivity testing are ordered for infectious agents such *as Streptococcus pneumoniae*, whereas a polymerase chain reaction assay would be ordered for *chlamydophilia pneumoniae* or severe acute respiratory syndrome (SARS), says Matsuoka.

"Specific testing may be done for the *Legionella* species," she adds.

- **Start antibiotics within four hours of arrival for pneumonia patients who are going to be admitted.**

The previous time frame called for antibiotics to be given within eight hours, so the new recommendation means quicker X-rays and laboratory testing will be needed, with earlier medical decision making about how best to treat the patient, says Matsuoka.

Average time to start antibiotics is just over three hours at Cleveland Clinic's ED, reports Fielden. "You should get the antibiotics started as soon as possible, not waiting for them to reach the inpatient unit where it may take up to eight hours to get them started," she says.

If you suspect that the patient won't take his

antibiotics when he goes home because he is noncompliant or lacks financial resources to obtain the drug, admitting him for observation for fewer than 24 hours is a good way to get two doses of intravenous (IV) azithromycin in, adds Fielden.

"A patient with pneumonia who we want to have 24 hours of IV antibiotics gets his first IV administration in the ED and the second one 24 hours later in the clinical decision unit [CDU], and then goes home," she explains. "He may only be in the CDU 20 hours, as the time in the ED is not counted."

The Ohio ED treats approximately 50 patients a month for pneumonia, with about 12 admitted to the observation unit and 54% admitted to the hospital, Fielden reports.

- **Assess whether patients can be discharged home safely.**

Consider the patient's ability to take medications and care of him or herself, says Matsuoka. A patient should have no more than one of the following characteristics to be discharged, according to the guidelines:

— temperature > 37.8°C;
— pulse > 100 beats per minute;
— respiratory rate > 24;
— systolic blood pressure < 90;
— oxygen saturation < 90%;
— unable to maintain intake by mouth.

According to the new standards, two factors determine whether the patient is admitted: The patient's ability for self-care at home, and whether the patient meets the above discharge criteria. For example, Matsuoka points to a wheelchair-bound pneumonia patient who lived alone with a caregiver, with problems eating and drinking due to poor muscle coordination from a previous stroke.

"The patient was febrile, tachycardic, and hypoxic, so he was admitted," she says.

- **Offer patients the pneumonia vaccine.**

At Cleveland Clinic's ED, nurses offer the pneumonia vaccine and influenza vaccines to anyone who presents with pneumonia and is discharged home, Fielden says.

"You usually associate it with influenza season, especially this one with the increase in pneumonia and mortality," she adds. "However, you should offer the pneumonia vaccine year round, since patients get pneumonia any time of the year."

- **Screen all adult pneumonia patients for SARS.**

The guidelines ask you to maintain a high level of suspicion for SARS when you see adult patients with pneumonia.

"Pneumonia isn't what it used to be," says Kucewicz.

"Ten years ago, pneumonia was pneumonia. Now it could be SARS or anthrax," she adds.

It is likely that numerous other suspected cases will be reported over the coming weeks, predicts Kucewicz. "If SARS spreads, it could present a worldwide crisis. No one sees this as going away soon."

She points to newly updated SARS guidelines from the Centers for Disease Control and Prevention (CDC), which ask you to identify patients who require hospitalization for radiographically confirmed pneumonia or acute respiratory distress syndrome without identifiable etiology, *and* who have one of the following risk factors in the 10 days before the onset of illness:

— travel to mainland China, Hong Kong, or Taiwan, or close contact with an ill person with a history of recent travel to one of these areas;
— employment in an occupation associated with a risk of SARS exposure;
— part of a cluster of cases of atypical pneumonia without an alternative diagnosis.[2]

"The numbers of pneumonia cases you are seeing need to be a trigger much more so than ever before," says Kucewicz. "Be very alert to how many cases you are seeing, because you need to be able to connect the dots."

The ED will likely be the first place that a

Pneumonia Resources

✔ The Infectious Diseases Society of America has published updated guidelines for treatment of adult patients with community-acquired pneumonia, including tables listing preferred treatment options and detailed management strategies. The guidelines can be accessed free at www.journals.uchicago.edu/IDSA/guidelines. Scroll down to "Update of Practice Guidelines for the Management of Community-Acquired Pneumonia in Immunocompetent Adults" and click on "Full text."

✔ The American College of Emergency Physicians (ACEP) has a clinical policy for adult pneumonia patients in the ED. The clinical policy can be accessed free at the ACEP web site (www.acep.org). Under "Quick Links," click on "Clinical Policies," "Clinical Policy for the Manage-ment and Risk Stratification of Community-Acquired Pneumonia in Adults in the Emergency Department."

SARS outbreak is detected, adds Kucewicz. "If there is a change in what's going on in the community, we will be the first to identify that change."

You also should be alert for clusters of pneumonia among two or more health care workers who work in the same facility, she says.

When a pneumonia patient is being admitted from the ED, the charge nurse screens with the new CDC guidelines before placing the call for the bed, reports Kucewicz.

"She stamps the ED nursing notes with a red-inked stamp that says 'SARS screening negative,'" she says. "The bed placement nurse also checks up on us by asking, 'What is the SARS screening?' To date, all of our SARS screening has been negative."

Symptoms of SARS mimic those of several other respiratory diseases, including many that are more frequent during the winter, notes Kucewicz. "Some of these diseases may give rise to pneumonia," she says.

References

1. Mandell LA, Bartlett JG, Dowell SF, et al. Update of practice guidelines for the management of community-acquired pneumonia in immunocompetent adults clinical infectious diseases. *Clin Infect Dis* 2003; 37:1,405-1,433.

2. Centers for Disease Control and Prevention. *Clinical Guidance on the Identification and Evaluation of Possible SARS-CoV Disease among Persons Presenting with Community-Acquired Illness, Version 2.* Atlanta; Jan. 8, 2004. ■

A billing analyst can find $300,000 for your ED

A dedicated billing analyst for your emergency department (ED) can generate hundreds of thousands of dollars that goes straight to the bottom line instead of just flying out the window, say two managers who have added about $300,000 a year. And that's a *net* increase in revenue after accounting for contractual discounts and reimbursement levels, and after subtracting the salary of the billing analyst.

The ED at Carondelet St. Mary's Hospital in Tucson, AZ, has had a billing analyst in place since 1996, and she has greatly improved the financial status of the department, says **Cassie Pundt**, RN, clinical manager of emergency services. "I know that we're capturing tons and tons of revenue that otherwise would have been missed," she adds.

The other billing departments and coders don't look at things as closely as they do, so many items are overlooked, Pundt says. "Other hospitals use their own billing departments and train people specially for ED charts, but we have a dedicated person for just reviewing ED charts within our own department," she explains.

The difference all comes down to the degree of expertise and how much the analyst can focus exclusively on ED charts, she says. Having one person who is experienced in the ED and can focus entirely on its charts yields far more revenue than just urging staff in the hospital's billing department to look more carefully at the ED charts, Pundt continues.

The St. Mary's ED billing analyst reviews all charts before they leave the ED and looks for missing documentation or errors that might result in reduced reimbursement. If anything is missing, she can go directly to the appropriate nurse. If the nurse has miscoded the acuity level, the analyst can study the care provided and has the authority to raise the acuity level when appropriate.

The St. Mary's billing analyst program was started by **Maggie McClellan**, RN, MBA, now director of emergency critical care services at sister hospital Carondelet St. Joseph's Hospital in Tucson.

She recalls that her ED in 1995 routinely was losing out on money it was rightly due.

"Every day, I would get a pile of either lost charges or inability to charge from our charging department because of inappropriate documentation or lack of charge slip being sent to that department," she says. "I had an employee who was on light duty, and I was looking for something for her to do. So I had her start checking records before they left the department to see how we could capture charges better."

That modest effort started paying off, so McClellan put more effort into it. The St. Mary's ED developed a process for using bar codes based on charges, and then the billing analyst used those bar codes and a thorough catalog of procedures to check charts for the necessary documentation.

Within a couple of months, she realized that the ED was recouping more money than it was spending on the billing analyst.

After a year of success with the effort, McClellan proposed to the hospital that it create a permanent

position for an ED billing analyst. After she showed hospital leaders the numbers from the past year, they couldn't say yes fast enough.

Over that first year, the St. Mary's ED billing analyst identified more than $1 million of charges that would have been lost, McClellan says. After applying the hospital's standard contractual discounts and other factors that reduce the actual reimbursement level, the ED actually received about $400,000 in additional revenue for the year. The billing analyst made about $12 an hour, so with her salary and benefits deducted from that sum the hospital was left with about $300,000 per year in new revenue.

"That's held steady for a while now," she says. "It's clear that you can recover far more than you pay for the billing analyst. It's kind of a no-brainer when you look at the numbers."

When she moved to the St. Joseph's ED across town, McClellan instituted the same program and is seeing the same results. Experience in the ED is important to making the billing analyst effective, so she looked for someone who had been there long enough to know the staff and intricacies of how the department worked.

She also wanted someone who could be extremely focused and "willing to be very nit-picky and thorough when reviewing the charts." She found a clerk who had been there for 15 years and moved her to the new billing analyst position.

McClellan says you can expect to pay between $12 and $17 per hour for a dedicated ED billing analyst.

St. Joseph's considered providing a bonus program to the analyst tied to the amount of revenue she generated from chart reviews but ultimately decided against it.

Such a bonus program could encourage the analyst to be too liberal in assessing charts and lead the hospital into fraudulent charges. Instead, the analyst participates in a bonus program open to other employees but not tied directly to the amount of revenue she generates.

The St. Joseph's ED sees more than 60,000 patients a year, and the billing analyst must review each of their charts before it leaves the department.

"She's busy but stays pretty well current," McClellan explains. "Mondays are bad because she has to do charts from the whole weekend. She has three days to do the reviews and usually makes it."

Aside from the increased revenue, McClellan points out one benefit of the billing analysis: She gets to see exactly how well individual staff members are documenting patient care.

"It does allow us to do focused reviews from a staffing standpoint to see who is appropriately documenting and who isn't," she says. "The nurse manager will speak to the billing analyst and see who isn't documenting appropriately and then speak to them or provide additional training." ■

NEWS BRIEF

ED volume increasing, most hospitals report

Some 68% of hospitals responding to a recent survey by the Schumacher Group said patient volume in their emergency department (ED) had increased in the past 12 months, with most reporting an increase from 1% to 10%.

Only 18% of respondents said overcrowding had caused them to divert patients to other hospitals, down from 36% in 2001. Seventy-six percent said a lack of coverage by physician specialists had caused them to divert patients, up from 65% who gave that response in 2001.

About 31% of respondents had lost some specialty coverage in the past year, with 33% citing uncompensated care and 26% citing medical liability concerns as factors. About half of respondents said the number of uninsured patients in their ED had increased in the past 12 months, and 77% said their ED was a major provider of primary care for the indigent and uninsured in the community.

The Schumacher Group is an ED management firm. For more information, go to www.tsged.com. ■

GUEST COLUMN

Advocacy may be a balancing act for CMs

By **Hussein Tahan**, DNSc, RN, CNA
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For case managers working in an acute-care environment, advocacy is a fundamental principle of the services they provide. Advocacy may be described simply as "wanting, getting, and doing what is in the best interest of the patient and the family."

In practice, however, case managers find themselves acting as advocates not only for the patient and family but for the hospital and provider of care as well. The needs and priorities of these parties may result in conflicts case managers are pressured to resolve.

Here are some of the stakeholders whose interests the case managers must keep in mind:

- **The patient and family**

Case managers advocate for the patient and family by ensuring the plan of care is appropriate and that treatments, tests, and procedures are available and accessible. It also means ensuring the care provided is timely, of the utmost quality, and in the best interest of the patient and family. Moreover, case managers ensure that the patient and family are making informed decisions about the care they opt to receive.

- **The hospital or provider**

Case managers advocate for the hospital by working with the care providers (e.g., physicians, nurses, social workers, and others) toward a timely patient's discharge and by negotiating with the insurance companies for the authorization of care and utilization of necessary resources.

These acts aim to enhance reimbursement and meet the hospital's goals and targets while ensuring patients receive safe and quality services.

- **The insurance company**

Working with representatives of insurance companies increases the complexity of the case manager's role as an advocate. The demands of these companies (e.g., authorization and certification procedures, reimbursement methods, utilization management policies, and quality reviews) often add another dimension and player to the advocacy process. Case managers are placed in situations where they are obligated to inform the patient/family and the provider of care that the insurance company has denied a particular treatment. This presents a potential for conflict: Is the case manager advocating for the insurance company, the hospital/provider, or the patient/family? The patient's perception of this aspect of the case manager's role affects the patient-case manager relationship.

If the patient perceives the case manager to be advocating for the insurance company, the quality of the relationship is compromised, trust is jeopardized, and the case manager may fail in meeting the set goals. Given those contexts, it's easy to understand why advocacy is a complex and demanding role for case managers. At all times, the needs of the patient and family are paramount, while dealing with the reality of the hospital's requirements and the demands of insurers. In the managed care environment, with its emphasis on cost containment and resource allocation, the advocacy balance becomes even more delicate.

In research that I conducted recently, I found that case managers — often working as part of a collaborative team that includes physicians, social workers, and others within and outside the hospital environment — used six main strategies for advocacy. They include:

- **Communicating** with each other, the patient/family, the hospital, the insurance company, and other community agents regarding care and related issues in attempts to ensure patients receive the care they need.
- **Teaching** to ensure the patient/family and others (especially physicians) were informed and knowledgeable about managed care regulations and practices, the decision-making processes at insurance companies, and procedures of denials and appeals. This is necessary for all involved to understand the reasons why certain

COMING IN FUTURE MONTHS

- Case managing the uninsured: A special report
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- What every case manager should know about Milliman USA guidelines
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decisions are made and their implications.

- **Resolving disagreements** that may arise among any of the parties: patient/family, insurance company, hospital/provider. The main purpose is not to compromise care and its related outcomes.
- **Brokering** of services needed by the patient and family while in the hospital or after discharge into the community. This is essential to ensure patients access the services they need and in a timely fashion.
- **Obtaining consent** to secure approval by the patient/family for treatments, tests, and procedures, and to confirm that the patient/family allow the hospital to appeal a denial on their behalf with the insurance company or state.
- **Supporting** to provide emotional support and psychosocial counseling to reduce anxiety on the part of the patient/family during illness and treatment.

Further, case managers employ a negotiation strategy to balance the needs and demands of the three parties (i.e., the patient/family, the hospital/provider, and the insurance company), to resolve conflicts, and reach more desirable outcomes. For example, if an insurance company denies treatment that the physician and the hospital decide is necessary, the case manager (along with the other team members) will negotiate on behalf of the patient. The goal will be to try to influence the insurance company to change its decision in favor of the patient and authorize treatment. If these efforts fail, the case manager and team members may turn to the physician and/or others at the hospital to negotiate with the insurance company.

In the ideal situation, the outcome of advocacy is a win-win solution, in which all three parties are happy. There are times, however, when one or more of the parties is not pleased with the initial outcome. In these instances, the case manager turns to negotiation skills in an attempt to reach the best solution possible.

Advocacy clearly is a balancing act, one that demands that the case manager, often working as part of a team, seek to meet the needs of the patient/family while satisfying the demands of the hospital/provider and the insurance company. These tasks are increasingly challenging. However, as case managers, we must not lose sight of advocacy as one of our fundamental roles and ethical obligations. To do so would not only undermine our effectiveness but also jeopardize the benefit we bring to the patients, their families, and the entire care continuum.

[Hussein A. Tahan, DNSc, RN, CNA, is the chair-elect of the Commission for Case Manager Certification (CCMC). The CCMC is the only certifying body for case management professionals accredited by the National Commission for Certifying Agencies. Hussein also is the director of nursing for Cardiovascular Services at Columbia University Medical Center, New York Presbyterian Hospital in New York City. Additionally, he is the co-author of The Case Manager's Survival Guide: Winning Strategies for Clinical Practice.

The article is based upon findings published in Tahan's 2003 doctorial dissertation, "A Substantive Theory in Acute Care Case Management Delivery: Provision of Integrated Care Using a Collaborate Core Team" (UMI Number 3088430).] ■

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. ■