HOSPITAL CASE MANAGEMENT™

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

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Clinical practice guidelines improve patient care at Connecticut hospital

Five tools guide treatment from admission through discharge

Through an integrated five-pronged approach, Danbury (CT) Hospital has been able to improve patient care for patients with any of 13 diagnoses.

The Clinical Practice Guidelines (CPGs) include five tools: clinical pathway, standardized physician orders, patient education materials, specific discharge instructions, and critical indicators for success. Each tool is linked to the others.

Since the implementation of the congestive heart failure clinical practice guidelines, patient compliance with discharge instructions has increased from 25% in 2002 to 70.8% by January 2004. Hospital readmission rates for congestive heart failure patients have dropped from 5.8% in fiscal 2001 to 3.8% in fiscal 2003.

Danbury Hospital has one of the lowest lengths of stay in the state of Connecticut, says **Doris Imperati**, RN, BSN, MHSA, CCM, director of clinical resource management.

Before the new system was implemented, the hospital used a traditional clinical pathway, initiated by nursing, to trigger interventions on a daily basis. The practitioners practiced in silos, with variable clinical outcomes. All quality review and variance analysis was conducted on a retrospective basis.

"The pathway wasn't being effectively used and did not address quality measures or needs of the patient throughout the continuum and did not include external benchmarking," Imperati says.

The hospital has completed CPGs for 13 diagnoses, including pneumonia, chronic obstructive pulmonary disease, congestive heart failure, stroke, caesarean, and other surgical procedures. The CPGs consist of five tools that interrelate with each other and help coordinate the patient's care from admission through discharge. Here are the components of the system and how they work:

- **Standardized physician orders.**

If a patient comes into the emergency department (ED) with congestive heart failure and is to be admitted to a medical unit, the resident on duty will use the appropriate order set to admit the patient.

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"The order set includes all the best practices and expertise of how a patient with congestive heart failure should be treated — laboratory tests, medical procedures, and the most up-to-date medications," says **Elizabeth Adler**, BSN, MHA, clinical quality manager.

- **Clinical pathway.**

When the patient is admitted to the unit, the nurses and clinicians on the floor use the clinical pathway to determine the expectations and clinical practices on a daily basis. For instance, on Day 1, they know to weigh the patient, check the laboratory report for the BUN level, and determine if the patient needs an ACE inhibitor or diuretic. The case manager monitors the process to ensure the tools are being used and the patient is getting the best possible care. If the order set wasn't used or something is missing, he or she intervenes.

- **Patient education booklet.**

Early in the stay, staff give the patient a full-color booklet about congestive heart failure and how to manage it on a day-to-day basis. The practice guidelines team collaborated with nursing and case management to develop the booklet.

"We told the people writing the booklets to pretend they were the patient and include what they would want to know. They are written so patients can understand what to expect during their hospital stay, their role in their care and discharge management, and what they can expect from their treatment team," Adler says.

- **Discharge instructions.**

The standardized discharge instructions prompt the physician through everything that is considered a best practice and includes specific information for the patient. For instance, it tells congestive heart failure patients to weigh themselves every day and what they should do if they gain weight.

- **Critical indicators for success.**

Each CPT has critical indicators that are developed by the CPT team.

The case managers concurrently review all the diagnoses and their critical indicators. The information goes to Adler, who enters it into a spreadsheet program and runs reports. The reports are given to each physician and nurse champion to take to their peers for feedback.

"When we analyze the data, if we have not met the goal, we get together with the treatment team to review the problem and come up with solutions," she notes.

"We are very conscientious about being on the

(Continued on page 100)

Physician-aligned CM model promotes teamwork

Patients like having the same CM each time

A physician-aligned model of case management has paid off at Danbury (CT) Hospital.

Assigning case managers to physicians rather than units has eliminated the adversarial relationship that sometimes occurs between the two disciplines and increased satisfaction among the staff and patients, says **Doris Imperati**, RN, BSN, MHSA, CCM, director of clinical resource management.

The arrangement provides the physician and the patient with a single resource for everything, she explains.

"The physician-aligned model works out really well. There is a tremendous amount of satisfaction for the physicians and patients as well as the staff. It has reduced the issues that sometimes arise when physicians and case managers work together," adds Imperati.

A case manager may be assigned to five physicians if they have a large practice or 15 or 20 if the practices are small. The hospital also has eight case managers who work with the hospital's large hospitalist service.

The assignments are set up so the case manager also is responsible for any physician who would cover for the physicians when they are away.

"The physicians are the people who drive the cost. When each physician has his or her own case manager, they develop rapport and they aren't offended when the case manager asks them something," Imperati says.

Giving physicians faster access

The case managers all have portable phones with caller identification. If the physician needs the case manager while she's with a patient, she can see who is calling and step out of the room to take the call. If it's a number she doesn't recognize, she can let the call go into voice mail.

"It saves the doctors from having to wait by a telephone for the case manager to answer a page," she notes.

On the rare occasion that a physician complains about a case manager or a case manager complains about a physician, Imperati encourages them to work it out. "Those who don't are few and far between," she adds.

The system is popular with patients, who often build a relationship with the case managers who coordinate their care every time they are in the hospital.

The arrangement improves patient care since the case manager already is aware of the patient's condition when he or she is admitted.

For instance, the case manager may know that every time a particular patient comes in, he has issues with his diabetes getting out of control.

"One of the big drivers for success is the leadership of the hospital. They set specific expectations that are goal-directed. They give financial and other recognition to physicians who are cooperative," Imperati says.

The 361-bed hospital has separate psychiatric and rehabilitation units, a health center clinic, and outpatient rehabilitation services, all staffed by case managers and social workers.

Staff include 10 social workers, three of whom work as case managers on the psychiatric unit along with one nurse case manager. The seven other social workers perform clinical social work rather than the typical discharge planning function.

"The hospital has integrated social work into case management, coming up with clearly defined roles for both disciplines and no turf issues," says Imperati.

The department has five clerical support staff. Two are on the unit, helping coordinate the day-to-day details that keep the patient moving through the system, such as arranging transportation and filling in applications for skilled nursing facilities.

The others work in the office, handling data entry, receptionist, and secretarial functions.

The 27 case managers all are registered nurses. Two are in management. One supervises the case manager directly. The other is the clinical quality manager and works with the Clinical Practice Guidelines (CPGs).

A social work consultant comes to the hospital two days a week and provides clinical supervision for the social workers to comply with licensing requirements that supervision be provided by a clinical social worker. The goal of the department is to assess 100% of the admissions.

The case managers handle all functions for the patient, including utilization review for payers; discharge planning; nursing home placement; arranging transportation; and quality management in real time, using the CPGs and the core measures from the Joint Commission on Accreditation of Healthcare Organizations.

"Danbury Hospital has put a lot of resources into the case management department to make sure the case managers are easily accessible and right there to help the doctor get through what needs to be done for the patient," Imperati says. ■

cutting edge for the best practices in medical, surgical, and obstetrical interventions. When we started, our tools were not as complete or thorough as we would have liked. They did not assist with concurrent review or any reviews that we anticipate coming from JCAHO [the Joint Commission on Accreditation of Healthcare Organizations] in the future," Adler points out.

Many of the hospital's patients have several primary and many secondary diagnoses and may have multiple providers of care. The clinical practice guideline is the tool that keeps everyone on the same page, she adds.

A committee with representatives from all departments in the hospital did research to come up with what other facilities were doing and came up with a plan for developing the clinical practice guidelines.

"We didn't develop these guidelines in a silo. Everybody has a role in creating a CPG," Adler says.

The committee did an internal study of the hospital's patients to come up with the diagnoses for which CPGs were in order.

Volume was one indicator

"Like many other community hospitals, we have an aging population, and our choices for some of the CPGs were influenced by volume. These include congestive heart failure, chronic obstructive pulmonary disease, and pneumonia," she says.

The committee examined the hospital's surgical procedures to see what procedures could be improved to benefit the patient and avoid excessive costs if the resources aren't controlled. For instance, the hospital does a lot of gastric bypass surgery for patients with morbid obesity, a procedure that is very expensive.

"We wanted to make sure all practitioners are treating the patients the same way, according to best practices," Adler notes.

The state's professional review organization has been looking at quality issues and standards of care.

"Whatever they're looking at, we want to look at," she says. "We want to use the best practices and keep our treatment patient-focused, but we also recognize that we are affected by external regulatory agencies."

The CPG for each diagnosis was developed by a multidisciplinary team with at least one physician member. For instance, because of the complexity of treatment for aspiration pneumonia, the CPG development team included a pulmonologist, a hospitalist, and an infectious disease specialist who worked together.

Each team has a physician champion who is an expert in that field, a nurse champion, a case manager representing the clinical resource management department, a medical director, and a pharmacist.

Other hospital personnel join the team if their input is needed for that particular diagnosis. For instance, the team creating the CPG for total hip replacement included an occupational therapist and a physical therapist.

As the manager of the team, Adler coordinates the activities, making sure the team stays on track and on schedule. There is an ad hoc member who checks over the order sets and laboratory tests to make sure they use the most current abbreviations.

"In the past, we referred to cardiac enzymes [as] 'CPK.' Now they're called 'CK.' We want to be current by calling the tests by the right abbreviation even though the laboratory may understand what we mean if we use the old terms." A single clinical practice guideline takes about two months to develop from the first committee meeting through implementation, Adler says.

"At the initial meeting, I think it's important to stress that each team member has specific responsibilities with the team," she adds.

As portions of the guidelines are developed, the physician champion shares them with his or her peers and gets input.

"Those are the people who will be using it, and if they have conflicts with the guidelines, we want to address it," she says.

The nurse champion educates the nursing staff about the CPGs and what role nursing plays to make the project a success. She makes sure that all the supplies needed for compliance with the CPGs are available on the unit so the physician can have access.

The clinical resource management champion works with the nurse champion to share information and data with the staff and educates the case managers about the guidelines.

"We want to make sure that everybody who is involved in using these guidelines gets the big picture. Communicating to the nursing staff and the physicians is very important. Outcomes are shared to show areas of improvement and where we need to improve," she says.

For instance, the hospital standard calls for any patient with a diagnosis of pneumonia to be on

antibiotics within 240 minutes of arrival to the hospital.

Analysis of the initial data from the CPG for pneumonia showed that some patients were not getting antibiotics within 240 minutes of arrival. Most pneumonia patients come through the ED, where they may stay more than four hours.

The committee met with the ED chief and arranged for the antibiotics to be administered in the ED. Now the average for administering antibiotics is within 170 minutes of admission.

Adler compiles graphs and spreadsheets for the leadership of the hospital, showing how each CPG is working.

The team continually reviews the CPGs, making changes as necessary. For instance, when there are changes in the hospital's formulary, the order sets are changed to include the latest recommended medications.

"We owe the success of this program to having the attitude that no one operates in a silo. Everyone affects outcomes, results, and potential improvements in the system, and everyone is held accountable," Adler says.

The hospital uses a paper system and is moving to a computerized system. Each piece of paper in each clinical practice guideline is numbered and entered into the computer system so if a unit runs low, the nurse can easily order replacements.

Adler is working with the hospital's programmers to create a computerized physician order-entry system. The computerized order-entry system was begun last July in the intensive care unit, then introduced to the medical and surgical floors and is scheduled to be implemented in cardiology next. "Because we have to keep a paper backup, I work with the programmers to make sure that what goes on the computer is identical to what is on paper," she says. ■

Hospital CM tackles cost of benefits program

Program to cut costs, out-of-network referrals

When health care costs for its employees soared by 60% and out-of-network claims increased by 20% in just a few years, Davis Memorial Hospital in Elkins, WV, took action.

The 90-bed community hospital called on the expertise of **Tod Thorpe**, RN, CPC-H, its former case management director, to manage the health care of its 650 full-time equivalent employees.

"We were in the same boat as any other employer, continually struggling with health care costs," he notes.

The hospital, which is self-insured, considered cutting planned services and shifting more of the cost to the employees as an alternative.

"With this program, we're hoping to continue to provide a broad range of services for employees without tacking on additional costs for them. If our health care dollars had kept going the way they were, we would have had to make an adjustment to the plan," Thorpe explains.

The program focuses on ensuring that out-of-network services are limited to those the hospital doesn't provide, getting employees back to work as quickly as possible, and developing employee wellness programs to target conditions that affect a large number of employees.

The initiative, begun in November 2003, already has gotten positive results. In the first quarter of 2004, after the hospital expanded case management to employees, the hospital's out-of-network usage dropped 10% compared to the first quarter of 2003.

Case managing your employee benefits is well worth the money it costs, Thorpe adds.

"The way health care is heading with the inflation factor and cost of coverage, the cost of the investment can easily be offset. As my CEO pointed out, any other multimillion-dollar budget would have a manager specific just for it, not just someone who is managing multiple other accounts," he says.

Before Thorpe — the only hospital employee dedicated to the program — began, he researched what other facilities were doing and found that few self-insured hospitals case manage their own employees.

"Some places do more aggressive benefits management, and others have workers compensation case management. I haven't found any other hospitals similar to our facility that have a structured program up and running," he adds.

Thorpe examined the hospital's plan of coverage and where the health care dollars were being spent. As a result, the hospital continued its contract with its third-party administrator (Benefit Assistance Corp.), which took care of claims, and switched to a different utilization company to handle its preauthorization.

"We didn't feel that the utilization company

was aggressive enough. In the years we had a contract with them, they had never denied any inpatient days," he says.

Thorpe uncovered a startling shift in health care expenditures. Five years ago, 75% of the employees' care was provided by the hospital and its providers. In 2003, the figure had dropped to 55%.

"It's money out the door. One of our big focuses was to be able to case manage these employees who were going out of network and get them back into our network," he said.

Because Davis Memorial doesn't provide some specialty services, such as neurosurgery and gastric specialty surgery, employees have to go out of network for those services. But in many cases, the employees were going out of network for services that the hospital does provide.

One goal was to ensure employees get all the services that the hospital provides, rather than getting them at another facility.

For instance, if an employee is going to another facility for neurosurgery, he or she still can have an MRI and other preoperative testing and work-up procedures at Davis Memorial and take the records to the other facility.

"This kind of testing runs into thousands of dollars. Since we have the same equipment as the other facility, we want to make sure we provide these services," Thorpe says.

If an employee has a debilitating illness and needs follow-up treatment, the hospital's rehabilitation services, home health services, or long-term care unit could provide the care after the critical portion of care is complete.

"We want them to come back to us and to keep our health care dollars here," he says. Before the new initiative in November, the human resources department approved the out-of-network services.

"The referrals to other providers were being managed by nonclinical personnel. We wanted to get a better control of why our people were going out of network," Thorpe notes.

Now the referrals for out-of-network care come to Thorpe, who examines them for medical necessity and takes them to a multidisciplinary benefits committee. If a decision can't be made at the benefits committee, the employee can request an outside review service.

The hospital continues to work with the third-party administrator on the medical necessity portion, but everything is reviewed internally by Thorpe or the benefits committee, which includes several physicians, nursing staff, and employees from human resources. The committee calls in specialist physicians as needed.

"We know more about our system and what we can and can't do here than an insurance company does, and that plays a big role. Our plan documents outline that services will not be covered if they can be provided without our network. We haven't changed that. We're just following it to the letter," he says.

Faster return to work

The program has another advantage — getting employees back to work sooner, Thorpe points out. "If we truly get involved in our employees' health care and managing their care, we know what is going on with them and we can get them through the system quicker." For instance, if employees need to go to rehab, Thorpe can get them into the Davis Memorial rehab program and get them back to work quicker.

"These employees are not only utilizing our health care dollars, they're off from work, and that also costs the hospital money," he says.

He works with the employees to get them back to work on light or modified duty whenever possible. Unlike workers' compensation case managers, Thorpe manages the care of employees injured both on and off the job.

"When an employee is off work, it costs the hospital money. Somebody has to work overtime to take up the slack in addition to costing health care dollars," he notes.

In the short time the program has been rolled out, Thorpe's interventions have resulted in a number of employees going back to work more quickly than originally anticipated.

For example, Thorpe says he worked with one employee to bring her back 54 days earlier than her physician had estimated just by clarifying her off-work slip. The move saved the hospital thousands of dollars.

"We no longer accept physician slips that just say the employee must be off work. We want the physician to specify what an employee can and cannot do," he adds.

Thorpe is working on ways to tie the employees' clinical data into the financially oriented reports that the third-party administrator typically produces. He wants to find out exactly what health care services the employees are receiving and come up with programs to improve the employees' health and minimize their health care costs. ■

CRITICAL PATH NETWORK™

New tool adds structure, productivity to meetings

Pre-existing tool adapted to strategic goals

All Saints Healthcare, a multifacility system in Racine, WI, has adapted a pre-existing template for meeting structure to more closely mesh with its strategic goals, creating a more organized meeting process, while at the same time, reinforcing key mission and vision messages with staff personnel.

The new template builds upon a seven-step meeting process originally developed by All Saints' parent organization — The Wheaton (IL) Franciscan System.

"Some of our leaders were using it, but some were not," recalls **Terry Doherty**, director of customer service and leadership development for All Saints, which includes two hospitals and a number of smaller medical sites.

"When we started on our service excellence journey [about three years ago] and put together our infrastructure, we asked people to use the seven-step meeting process," she says.

"As we evolved and encouraged leaders to become more actively involved, we adapted it to our pillar goals — our strategic goals for the organization," Doherty explains.

About two years ago, she says, All Saints began working with The Studer Group, which advised it to use the template more often.

"It helps employees to understand how the issues they're meeting about relate to the big picture; we now connect every meeting to [at least] one of our pillar goals," Doherty says.

Part of All Saints' infrastructure for service excellence consists of 13 teams focused on some elements of service.

These multidisciplinary teams cover four different areas of patient satisfaction (emergency department, inpatient, medical group, outpatient), as well as support services such as communication, measurement, reward and recognition, and service recovery.

The leader of each team, in turn, is a member of the system's steering team.

"We started working with them and tried to give them tools and information they could utilize to help their work go more smoothly, and this was one of them," Doherty explains.

The seven steps of the meeting process are:

1. Review roles.
2. Review objectives.
3. Review agenda.
4. Work through agenda.
5. Review meeting and record assignments.
6. Identify next steps; plan next meeting.
7. Evaluate meeting.

The six pillars are as follows:

- **Mission Integration.** Actions, processes, and decisions are rooted in, and consistent with, The Wheaton Franciscan and All Saints Healthcare's Mission, Values, and Vision.
- **Financial Viability.** All Saints Healthcare achieves operating margins and other financial ratios established in the system strategic financial planning process to generate the capital necessary to fund strategic and operational needs.
- **Clinical Excellence.** Clinical quality and clinical outcomes in key service lines will exceed regionally and/or nationally established standards.
- **Patient Service.** Patients within the communities we serve will experience superior and compassionate service.
- **Health Care Employer of Choice.** All Saints Healthcare values its employees and provides a superior work environment that supports

recruitment and retention.

- **Preferred Partner of Physicians.** All Saints Healthcare and physicians choose to work with each other over other market alternatives.

The Studer Group, Doherty notes, advocates five pillars; the other, "Mission Integration," is unique to All Saints. **(The chart, below, illustrates a staff meeting template.)**

The number of pillars addressed depends on the focus of the meeting, she explains. "You might have only one pillar — or all of them — depending on the issue.

"For example, I head up a project team that helps conduct and serve as a resource around our employee survey, so at every team meeting we have an agenda that incorporates not only the seven steps but is also connected to all the pillars," Doherty points out.

She concedes that it is difficult to accurately assess the impact of this tool. "It's hard to say; there's no way to measure it," Doherty says. "However, we reintroduced it to all of our leaders with the pillars, in June 2002, and encouraged them all to use that. In all the meetings I go to, I see it used."

She sees a number of benefits that flow from this tool. "I think that the biggest is that employees have a better understanding of how their daily work connects to our values and goals," Doherty explains.

Staff Meeting Template

ALL SAINTS HEALTHCARE
MEETING AGENDA

Group: Employee Survey Team **Location:** **Date:**

Facilitator: **Reflector/Recorder:** **Timekeeper:**

1. **Review Roles:**
2. **Review Objectives:**
3. **Review Agenda:**
4. **Work Through Agenda:**

PILLAR / GOAL	TOPIC	PRESENTOR	EXPECTED OUTCOME	TIME
Mission Integration	Reflection		Connect to purpose	
Healthcare Employer of Choice	▪ Review of Assignments from February ▪ Action Plan Stories – Ann, Bob, and Jim ▪ Other ▪ Updates & Decisions ▪ Org. Action Plans ▪ Abbreviated Survey Debrief ▪ Q & A and issues ▪ What going well? ▪ Response Numbers ▪ Next Steps		Obtain highlights and opportunities for change or next steps Update Update & identify & resolve issues	
Stewardship	**5. Review meeting record & assignments** **6. Identify Next Steps** **Plan Next Meeting**		▪ Carry out our responsibilities to support strategic & financial objectives	
Excellence	**7. Evaluate meeting**		▪ Improve the way we work	

Source: All Saints Healthcare, Racine, WI.

"Another benefit is that when our leaders start to think more in this way, they will be able to make better connections for employees. At staff meetings, information is more balanced if they think about what the meeting is saying in terms of our goals; it's a more balanced approach to decision making, problem solving, and the giving and receiving of information," she adds.

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National model begun at regional level

IHI's model improves care of diabetes patients

The Breakthrough Series Collaborative model effectively employed by the Institute for Healthcare Improvement (IHI) on a national level has been translated successfully to the regional level in the state of Washington, achieving significant improvement in the self-care efforts of diabetes patients and clinical improvements in areas such as blood sugar and cholesterol.

The initiative, whose accomplishments were reported in two articles in the February 2004 *Joint Commission Journal on Quality and Safety,* was cosponsored by Qualis Health of Seattle, the Wash-ington State Department of Health, and the MacColl Institute for Healthcare Innovation at Group Health Cooperative of Puget Sound. One article reported on statewide diabetes collaboratives, while the other focused on two participating clinic teams.

In the statewide collaborative report, there was a 50% improvement in the number of diabetes patients who received foot exams; a 49% improvement in the number of patients who received blood pressure readings; and a 35% improvement in the number of patients who received blood cholesterol tests. Outcome measures showed improvement of 12% among patients whose blood sugar dropped; 13% in the number who lowered their LDL; and a 7% improvement in the number who lowered their blood pressure readings.

"Most collaboratives have been done nationally by IHI, and only by people with heavy financial resources," notes **Connie Davis**, ARNP, MN, associate director for clinical improvement/improving chronic illness care at the Center for Health Studies, part of the Puget Sound Cooperative. The Center also directs the MacColl Institute.

The group worked with state health plans and developed a statewide support system for the chronic disease self-management program. It also brought rural clinics into the effort.

Just what was this IHI-inspired model the state groups implemented? "It's a learning model that uses what is known about how adults learn best," Davis explains.

"You bring people together four times over the course of a year with experts who teach you how to make changes, and between meetings you have calls, monthly reporting, ways of sharing information, and a web site with downloadable tools."

This approach, she says, keeps everyone in the cohort engaged. "It's very complicated to try to do this, but clearly there were improvements, and we're very definitely pleased with the results."

There were several keys to success, Davis says.

"You teach the teams they can't just add on to the system; they have to redesign it, and we teach them how to do it," she explains. They are taught, she says, to be efficient, plan ahead, and reach out and not wait for disaster to happen. "This is a whole different way of thinking."

The teams were provided with a structure; each of the clinic settings had teams comprised of representatives from administration, physicians, and nurses. Implementation was based on a chronic care model with evidence-based principals. "The team members did not have to grope around; we gave them something that would work for them," Davis notes. The approach is based on incremental improvement, she explains. "You try it with one patient; if it works, you go, and so on. All the while, you are measuring."

A learning collaborative, Davis emphasizes, "is a very powerful implementation tool." Peer pressure and peer support are key. "You know you will see them again in three months, and they'll ask you how you did," she observes. This "all teach, all learn" approach uses a number of creative techniques, such as story boards, to share information.

The final ingredient for success, she says, was "great clinical expertise." The top endocrinologists passed on their knowledge to family physicians, and in this manner, Davis says, "raised all the boats."

The two participating teams highlighted in the second article — Olympic Physicians, a rural clinic in Shelton, WA, and The Polyclinic, a large urban specialty clinic in Seattle, also achieved impressive results, but perhaps just as important was the recognition that "You don't treat every clinic like they're all the same," says **Donna M. Daniel**, PhD, epidemiologist and project director for the process improvement support center at Qualis Health, and lead author of the article.

"You must recognize that each has a local environment that is so powerful, and a basic tool kit will not meet all needs," she adds.

At Olympic, the keys to success included understanding the importance of the chronic care model provided by Davis' group.

"It's an incredible framework for directing and guiding health care professionals who want to create the best care for their patients," Daniel says. "It's very easy to grasp and to use to guide their work, and the small-scale test of change can work for any improvement you create in an organization."

The team also attributed its success to the ability to provide routine feedback. "By integrating the clinical information systems of the various organizations [through the Diabetes Electronic Management System, or DEMS], we were now able to give reports to the caring team — we could identify those patients whose hemoglobin A_{1c} [rates] are unacceptable, who has had heart failure, and so on," Daniel says.

In addition, Olympic was able to hook up with a local hospital that had a diabetes wellness center and shared resources. "Community linkages and resources are part of the chronic care model," Daniel notes.

The other collaborative had an entirely different set of success keys. One, for example, was "an extremely vocal medical director."

"One of the things that does not get written down enough is personalities. If you have a strong — but not necessarily aggressive — individual who commands incredible respect and passion, and who demands that care be the best it can be, they can be an incredibly powerful key to an intervention like this moving forward," Daniel explains.

The promotion of collaborative methods also was considered critical. "This started with one or two docs and their patients; then we rolled it out to the other docs who had not been so enthusiastic," she points out. "This spread of practitioners can be very motivating."

The partnership with a health plan provided significant financial and staff support. "DEMS is one of the resources that needs to be provided," Daniel adds. "But for it to be a viable option, you need to have someone enter the data in for the patient — from paper to electronic — and this can be time-consuming. Many clinics got creative; they used reception staff when times were slow to enter chart information. They used folks from local colleges; nurses would come in on weekends, as well as physicians. In this situation, the health plan partnering with the clinics ponied up the necessary funds."

Later, she explains, the clinics figured out ways to get grants from pharmaceutical companies to fund data extraction.

Strong on model

Daniel also is a strong supporter of the collaborative model. "The face-to-face meetings provide opportunities for people to develop trusting relationships," she says. "During these meetings, teleconferences, and e-mails on a daily basis, and creating story boards — all these modalities for sharing create a situation where the most change and improvement can occur."

Is this model replicable anywhere else? "That's the overall message," she says. "It's hard to participate in national collaboratives, but we did it on our level with minimal registration fees, much less travel, and we tried to minimize time out of the office by having meetings on Mondays and Tuesdays. We were able to realize results similar to those of the national collaborative, and we believe it can be replicated."

In fact, she says, the Washington group went to the Centers for Medicare & Medicaid Services and told it they thought the model could be replicated in a quality improvement organization (QIO) program. "Currently, over 100 IHI-like collaboratives are being reported from the QIO community on statewide and regional levels," Daniel reports.

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Care program incorporates office-based CM approach

Initiative expands as physicians learn its purpose

Physicians aligned with Sutter Health in Sacramento, CA, are giving glowing reviews to a care coordination program they once failed to recognize, pleased that it is meeting myriad patients' needs and saving office time in the bargain.

What began as a trial medical office case management program — featured two years ago in *Discharge Planning Advisor* — has evolved and expanded and been absorbed back into the Sutter Care Coordination Program, explains **Jan Van der Mei**, RN, care management director.

"Physicians are delighted with the program and find that it is very valuable to them," she says, noting that in addition to addressing patients' psychosocial needs, the program assists patients with obtaining transportation and applying for discounted or free prescription medications through various drug company programs.

Physicians surveyed about the program report "extreme satisfaction," Van der Mei adds.

What is ironic about the situation, she points out, is that earlier physician response to the care coordination program was less than enthusiastic, even though it offered the same benefits now being provided.

When that program — a centralized nurse/social work model — expanded in 1997, "we found our own patients," Van der Mei says, drawing from emergency department (ED) patients and those who were admitted to the hospital more than two times in six weeks and through health risk screenings of new members of the Sutter managed care organization.

"We connected with the physicians, told them what we were doing, but got very few referrals," she says. "[Physicians] thought we were gatekeepers and were suspicious of us. Now they truly understand what case management is."

In 2001, the medical director of the Sutter Physician Alliance (SPA) approached Van der Mei with the idea of putting nurse case managers in the physician office setting, she notes. "He was looking for opportunities to provide a value-added service for SPA physicians and felt this was one way to accomplish that goal."

After meeting with physicians, who gave examples of the kind of assistance and support they were looking for, Van der Mei began to put the program together. "I felt this was a natural progression of Sutter Care Coordination."

Three registered nurse full-time equivalents (FTEs) were added to her budget, which already supported four RNs in the centrally located care coordination program.

Nurse case managers were based in "care centers," each of which house a group of between eight and 10 physicians in the Sutter Medical Group, Van der Mei adds, with each RN assigned between 12 and 15 physicians. "Although space is always an issue, we were able to find space."

Independent practice association (IPA) physicians who were exclusively linked with Sutter also were included in the program, she notes, but not those who have contracts and allegiances with other systems and payers.

Sutter didn't want to get involved in treating patients who were members of other managed care plans, Van der Mei adds.

"With the original care coordination program," she explains, "the impetus of it was us taking on full risk, so the bulk of the patients in that program were managed care. When we move into the physician offices, we have to take *all* their patients, not just managed care patients."

"If we're working with physicians who are exclusively with Sutter, we even work with their MediCal and other patients," Van der Mei says.

Now the program is about 60% managed care,

she adds, "but we still meet our return on investment." Sutter physicians and hospitals have more than enough patients to keep them busy, Van der Mei notes, "and don't really want patients who are more appropriately treated elsewhere to be in the hospital."

Saving time, meeting needs

Two RN case managers were dedicated to the IPA, she continues. "They each have a few physicians in the medical group, as well as the IPA physicians, and work from their office at the care center. They do go to the IPA physicians' offices to see patients — generally during a scheduled appointment — and make rounds if a patient is in the hospital.

"We tried having staff stay at the IPA offices, but they were in the way — these are independent offices, and there was no [extra] space whatsoever," Van der Mei adds.

Nurse case managers working in the central areas of the care centers, however, found they could do some effective intervening when they overheard medical office assistants telling patients who called in with problems that they should go to the ED, she notes.

"The case manager was able to say, 'Do you want me to talk to the patient?' and could divert a lot of them," Van der Mei adds. "The physicians didn't want patients turned away, sent to the ED, but the medical assistant wanted to tell [the patient] something and didn't have room on the schedule."

Having case managers handle patients — in many cases without having them go to the ED or come to the office — has made physicians happy, she points out. "Patients who were calling the physician every week are now calling the case manager."

Two of the original nurses with the office case management program found it "wasn't a good fit for them," Van der Mei says, in part because they tired of having to convince physicians of the program's value. After they quit and she was hiring two new RNs, she adds, "I realized I really needed to hire them into the care coordination program and incorporate all of the office case management into that."

"[The office case managers] needed the support of the social workers and the health care coordinators who do the ongoing monitoring," Van der Mei says.

"So while we started out saying that office nurse case management was a separate program, it really became part of care coordination," she explains.

Now each social worker and health care coordinator is designated to work with two nurses, she adds, and, in turn, with the physicians to whom those nurses are assigned.

"So there are really teams," Van der Mei says. "The physicians not only have nurses but social workers. When a nurse is out there and gets a psychosocial case, it goes directly to the social worker, and the physician is aware of that. The social worker then discusses things with the physician."

While it took physicians a little while to understand that the nurses were part of a larger team that included staff located elsewhere, the care coordination program now gets between 175 and 190 physician referrals a month, she notes. "We used to get maybe 10 a month."

After the first-year physician satisfaction survey brought positive results, the decision was made to expand the program from Sacramento to the Roseville, CA, area, Van der Mei says. It now serves about 2,000 patients, compared to some 1,200 when the nurses first moved into office case management, she adds, while the original care coordination program served about 900 patients.

Patient satisfaction surveys also have been very positive, she adds, although there was some initial confusion because patients didn't connect the nurse who was helping them with the care coordination program. "They really think the case manager in the office works for the physician," she adds. "So we've started putting the nurse's name on the survey."

SCCP staff now have the ability to create a daily report identifying all patients in the program who have been admitted to the hospital, Van der Mei notes. "We also identify patients who are in one of the Sutter managed care plans but not in our program who might be appropriate for follow-up."

This capability also allows her staff to follow up with their patients who are admitted to make sure their discharge plan is adequate and that they have any new medications that might have been prescribed, she says.

While the care coordination program originally had an independent database, in March 2003, it was added to the electronic medical record model used by Sutter's medical group, Van der Mei explains. As a result, physicians now have access to "a summary of everything we're doing."

"That's been great," she says. "It linked us very closely to them. The IPA is not on the electronic medical record [EMR], though, so we always need to have a paper process for communication as well as the EMR."

A current focus for the care coordination program is end-of-life, advance care planning for patients, Van der Mei notes, and her staff recently went through four days of training and planning on how to assist physicians in this area.

Advance care planning, she points out, is one of the outcomes measured for certification of Sutter's disease-specific programs by the Joint Commission on Accreditation of Healthcare Organizations.

"Our goal is that patients will have at least the beginning of this discussion within 90 days of entering the program," Van der Mei says. "[Lack of such information] is one of the problems on the care plan for each patient. It's important for everyone to do this so our loved ones know what we want."

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Research to separate DP outcome, process goals

PhD candidate fine-tuning new screen

After working 15 years as a discharge planner and earning masters' degrees in nursing and clinical research, there's an incongruity that **Diane Holland**, RN, MS, MBS, who is now pursuing a PhD through the doctoral program at the University of Minnesota School of Nursing in Minneapolis, would like to resolve.

"One of the [discharge planning issues] I've always been impressed with," says Holland, "is the confusion that I've had related to outcome goals being the same as process goals.

"Discharge planning is accepted to be a process, but if you consider the goals of the traditional discharge planning screen, they're all measured against the goals of the outcome of the entire screening process," she points out.

With that perceived disconnect in mind, Holland is making a distinction between process goals and outcome goals in her doctoral research.

"Where the [position espoused in] discharge planning literature is to have the outcome of screening as disposition at discharge, length of stay, readmission, etc.," she explains, "I'm instead looking at each step of the process."

Holland says she is working to develop a screen that identifies, early in their stay, adult patients who will use specialized hospital discharge planning services "based on the goal of screening to assist in the next step of assessment."

"It is mandated by Medicare that hospitals identify early in their stay people who would suffer adverse health effects without additional discharge health evaluation," Holland points out. But she notes that in working on the screen, she has been "really unable to distinguish the goal of the screening or the outcomes associated with the screening from the goals of the entire discharge process.

"In terms of rethinking the discharge process," she goes on, "it's very difficult in the first place to really link discharge planning uniquely to patient outcomes of hospitalization. It's even tougher to be able to tease out any of the individual steps in the process in terms of their unique contribution to process or outcomes."

With her screen, Holland says, the idea is to screen patients to determine in a timely manner whether they will use additional hospital resources. Looking at readmission and length of stay to judge the effectiveness of the process "really misses the mark," she adds.

So far, she has identified four variables — advanced age, prior living status, disability score, and self-reported walking limitation — that determine with "reasonable sensitivity and specificity" those who will use additional resources, Holland says. "All [the variables] are easy for a nurse or health care provider to assess."

Patients who had low scores on the screen yet still used additional discharge planning services, she hypothesizes, are "externally motivated in terms of health needs." With that in mind, she is adding another variable — "health motivation" — to see if it improves the screen's effectiveness.

Those who scored low on the screen — meaning they didn't match the four original variables — but still needed extra help at discharge "appeared to be people who didn't seem able to engage in the discharge planning process," Holland says. "They didn't feel it was their responsibility to meet their

continuing care needs, so they didn't even want to participate in their own discharge planning."

As an example, she mentions a young woman who flew to Rochester to receive care at the Mayo Clinic and, instead of flying home, wanted to drive. The young woman needed help finding a van, Holland says. "It's the day of discharge, and there is the first note from the discharge planning service that says 'called to see patient with questions regarding transportation home.'

"It's the day of discharge that finally this situation gets illuminated, when the health care team has assumed there's no issue with this person's ability [to arrange for the van]," she points out.

"I would have called a car rental place," Holland notes, adding that the patient's failure to take the initiative well illustrates a concept known as "motivation in health behavior."

"Those who are intrinsically motivated tend to take it on themselves, define their health by their own standards, and look on the health care team as helpers and facilitators," she explains. "Those who are extrinsically motivated look to others."

By adding that variable, Holland expects to pick up those who will need extra help at discharge, but not for the usual reasons. "Because they're not functionally disabled or elderly, they're the type of patient that often slips through the cracks."

Traditionally, the outcomes being considered always are length of stay and rate of readmission, whether one is evaluating any piece of the discharge planning process or the process as a whole, she continues. "You can't gain an understanding of the unique contribution of any one step in the process by looking at outcomes that are also assigned to every other step. When screening, you have to stand back and look at the first step and hope it leads to the next step."

It is more meaningful, Holland contends, to look at "whether or not the actual demands of the patient once [he or she] went home were planned for and met by the discharge plan," she adds. "If a family member was requested to meet some sort of continuing care need, did the family meet it, or did someone else have to pick that up? If the plan was for the son to help his father with intermittent catheterization, was that what happened, or did the plan have to be changed?"

To date, Holland notes, she has worked on her screen in only one health system with one model of discharge planning but hopes to continue this line of research in other health care settings and using other models. At present, she is preparing two manuscripts — one mostly about the screen she has developed and another that revisits the outcomes associated with both the discharge plan and the process, she adds.

"I'm working on the screen, refining the screen, and will move down the line in terms of other steps," she says, "like, say, the assessment process — how to assess meeting the person's continuing care needs. Are there tools that will help in light of appropriate outcomes or goals as a *step* in the process?"

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CE *questions*

1. Which of the following is not one of the five tools included in the Clinical Practice Guidelines at Danbury (CT) hospital?
   A. standardized physician orders
   B. patient education materials
   C. JCAHO standards
   D. critical indicators for success
2. At Danbury (CT) hospital, case managers handling which of the following functions for the patient?
   A. utilization review for payers
   B. discharge planning
   C. quality management in real time
   D. all of the above
3. When health care costs for its employees soared, self-insured Davis Memorial Hospital in Elkins, WV, took which of the following steps?
   A. charged its former CM director with managing the health care of the employees
   B. cut planned services
   C. shifted more of the cost to employees
   D. all of the above
4. According to Patrice Spath, RHIT, the best approach for eliciting cooperation from other members of your health care team is to give them specific directives.
   A. true
   B. false

Answer key: 1. C; 2. D; 3. A; 4. B

GUEST COLUMN

Taking charge when you're not in charge

When you have responsibility without authority

By **Patrice Spath**, RHIT
Brown-Spath & Associates
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Case managers often find themselves charged with the responsibility for solving problems without the accompanying authority needed to fix the problem. This can be very frustrating. You can't issue direct orders to solve the problem, so why should anyone listen to your suggestions?

Perhaps the head of finance has requested that all physicians document a definitive diagnosis in patient records within 12 hours of hospital admission. You are held responsible for making sure this gets done, although you lack the clout necessary to change physician behavior.

If you are like most case managers, you regularly find yourself in situations where you have the responsibility but not the authority to get things done.

For instance, case managers often arrange for patients' post-hospital care needs, and yet the power to order some services rests with the discharging physician. Maybe you head up a multidisciplinary clinical process improvement team whose members don't report to you. Or maybe you do have nominal authority but find that your charges don't respond to your directives. How do you approach situations like this? When you're not the boss, how can you gain the cooperation of other members of the health care team?

You won't get support from others by issuing directives. Even those in senior management positions shy away from directives, choosing instead to manage by persuasion.

Management by persuasion involves listening seriously to other peoples' ideas, valuing their suggestions, and turning to others for advice. Unless you really are in charge, you're not likely to elicit cooperation from other members of the health care team by telling them what to do. In fact, colleagues may resist your instructions precisely because they don't like being told what to do by someone who isn't their boss.

Use the word "teamwork" cautiously. Teamwork does not mean people should do exactly as they are told. Instead of issuing directives, ask questions to solicit input from others, offering your ideas as part of a solution. And then do something that models or demonstrates what you'd like to see happen. If you're advocating a cost-savings initiative, for example, spend some time researching one particular patient care practice and then propose some ways to reduce costs.

Real leadership, of course, has never been a matter of mere formal authority. You've seen it — a meeting is meandering, the outcome uncertain, and then one participant introduces significant new facts or insights. Suddenly, the tenor of the meeting changes, and information carries the day.

Occasionally, the information provider is smarter or more experienced than other participants. More often, the participant has done his/her homework and so knows things that others don't. Having information elevates your ability to negotiate change when you're not the one in charge.

When approaching a problem situation that can only be solved through cooperation among several individuals, the first order of business is to write down exactly what you want to achieve. People typically plunge right into a discussion of the problem and start arguing over what to do.

To be effective leaders, case managers must think systematically — that is, set a goal, gather and lay out the necessary data, analyze the causes of the situation, and propose actions based on the analysis. When discussing the problem situation with others, keep people focused by asking appropriate questions, such as: "Do we have the information we need to analyze this situation?

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Can we focus on figuring out the causes of the problem we're trying to solve?"

Develop synergy, not divisiveness. By helping caregivers achieve their goals, case managers will be more effective. Don't think of the world in two views: Either, I win, or you win. This leads to divisiveness. Case managers must work with others to constantly do more with fewer resources. Thus for case managers to be successful, they must make sure that everyone wins — this produces synergy.

To create synergy among the health care team, start by finding out the answer to, "What's in it for me?" from each group of caregivers (physicians, nurses, therapists, post-hospital providers, etc.). You'll likely discover that each group values something a bit differently.

By knowing what each group values, you can create collaborative partnerships that seek to meet everyone's expectations. The health care team cannot even begin to agree on how patient care should be provided until there is a common definition of the goal — one that reflects an understanding of everyone's values (including the patient) and how the values diverge and converge.

If you're not the boss, what kind of feedback can you provide to others? One thing that's always valued is simple appreciation — "I thought you did a great job." Sometimes, too, case managers will be in a position to help other members of the health care team improve their performance through coaching.

Effective coaches ask a lot of questions. ("How did you feel you did on this project?") Effective coaches recognize that people may try hard and fail anyway. ("What made it hard to accomplish this task?") Even when you are not in charge, you can offer people a few suggestions for improvement. But be careful that you explain the observations and reasoning that lie behind them.

Gaining buy-in for process changes can be difficult when you are not the boss of everyone involved in the process. Engaging others and responding candidly to their questions and concerns is the best way to gain support, yet there are likely to be some quiet dissidents.

Don't wait for 100% buy-in to the process change, or new ideas will never move forward. Early, credible supporters of the change will bring others into the fold over time. One-on-one personal interaction with opinion leaders to gain their support is usually time well spent.

It is always worthwhile to step back and review your style of personal interactions and ask how effective it is in solving problems.

If you are goal-oriented, authoritative, and decisive, you may find that these traits inhibit collaboration with other members of the health care team. If you are primarily focused on maximizing the collective creativity and innovation of everyone, your personal problem-solving goals may be easier to achieve. ■

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. ■