AMERICAN HEALTH CONSULTANTS®

HOSPITAL CASE MANAGEMENT™

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

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Are you case-managing your hospital out of business?

Case managers must adjust to changes in managed care for hospitals to stay afloat

Is your case management department managed care-savvy? If not, your efforts could be costing rather than saving your hospital money.

A main concern of some experts we talked to is that the staff delivering care in hospitals are generally uninformed about exactly what managed care is and how it works. **Connie Burgess**, MS, RN, a health care consultant in Long Beach, CA, is quick to point out that there are many exceptions to that, but, "in general," she says, "front line staff don't understand how managed care works. Often they don't understand what their hospitals are trying to achieve because they're not in sync — they're not on the same page."

To many, the terms "HMO" (health maintenance organization) and "managed care" are synonymous. They don't understand the various payment mechanisms. "The lack of education about managed care for the clinical staff is huge," Burgess says. Burgess' firm specializes in managed care reorganization and educates hospital staffs so they can create their own clinical models that meet the needs of the patient.

Richard Vernick, MD, senior vice president of St. Petersburg, FL, consulting firm the Hunter Group, says he and his colleagues saw an increase in the number of managed care denials in 1999. "That has been happening for lots of reasons, including administrative ones," he says, "such as where someone didn't register the patient correctly or didn't get a preauthorization. The plans

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COMING IN FUTURE ISSUES

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■ **'Dashboards':** Some of you have never heard this term; others are inundated with it. You will be hearing more about dashboards and should know what they are and how they are important to your career

■ **Patient safety:** Is there life after the IOM report? Keep up on the new mandates and your new responsibilities

■ **Making disease management work from a reimbursement standpoint:** How to bridge the gaps between patient care and payers

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may stall legitimately by asking for pending information or documentation." Plans are citing a lot of reasons for holding up claims from being paid or for denying them outright, and that hurts the hospital's cash flow.

Ed McCarthy, another senior vice president at Hunter, says sometimes a hospital will negotiate an increase in a per diem for an inpatient stay, and everyone thinks it's done pretty well. "But as there's been an increase in downgrades in the level of care they'll pay for or an outright denial of a day — at the end of the stay, predominantly — that really negates the increase you got through the negotiation."

> "If I'm planning care and I don't know what the patient's benefits are, I might recommend treatment that is outside the benefits. . . . I stayed on automatic instead of individualizing that patient's care."

Both Hunter consultants say that because of this increase in medical necessity denials, the departments of a hospital must work together better than ever before. "Case managers have to make sure admitting is getting everything it needs — the name of the plan, where to send the bill, whether there is a physician group involved, and preauthorizations," McCarthy says. "Is the case getting denied a day at the end of the stay? Or downgraded to a SNF [skilled nursing facility] day payment rate rather than the acute med-surg rate they thought they were getting? Is that being appealed and tracked before it's outright denied? What is the business office actually getting paid? What are they writing off because they think they won't get anywhere with the denials process?"

However, why would it be important for hospital-based case managers to keep up with changes in managed care? How do managed care developments affect case managers' day-to-day jobs? Burgess says managed care should be important to case managers because the level of insurance benefits available to the patient is almost as important as the patient's diagnosis. "If I'm planning care and I don't know what the patient's benefits are, I might recommend treatment that is outside the benefits. And I've done it out of ignorance, not

Managed care or not, staff work harder, faster

There aren't many managed care contracts yet at Valley View Hospital in Glenwood Springs, CO, where **Linn Kight**, BSN, RN, is clinical path coordinator. "But even so," she says, "the health care environment is such that we have to work harder and more efficiently than ever before. That's true of a facility whether or not it is heavily affected by managed care."

Insurance companies follow the example of Medicare and Medicaid, and those dollars are shrinking, so reimbursement is lower in any case. "There is no hospital in the country that has not been impacted," she says. "No one is exempt from tightening the belt and working at appropriate utilization of services, not just within the clinical setting but in all the support departments as well. But it's harder for some hospitals than others, depending on their payer mix."

Kight sees an advantage to HMOs having copies of a facility's pathways and patients being on pathways. "If a company knows a patient is on a pathway, case managers have to answer very few questions from the company," she says. "The people from the company know what's on the pathway and know what time frames to look at for length of stay. That makes it easier and less time-consuming for the case managers." When a patient is not on a pathway, she says, private insurers as well as managed care companies ask more questions and need more information. "Then they ask, 'Why is the patient still here? He doesn't need that intensity of service. You need to look at getting him discharged,'" Kight says.

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out of good case management. The patient's plan may cover this, but not that. I could have planned it differently, so I've done a disservice to the patient. I stayed on automatic instead of individualizing that patient's care."

She says case managers have to ask themselves: What are the key issues for this patient? What support systems does the patient have? What is the discharge plan? What benefits are available to support the patient in his illness? What resources does he have? Case managers have to look at everything from a patient's pathology to his discharge plan and build those factors into every patient's plan of care.

What is the objective of case management?

"Get a good understanding of managed care," advises Vernick. "Why are case managers managing cases? For better outcomes? To improve the reimbursement level of the hospital? To increase the effective capacity of the hospital by increasing the number of patients put through?" He says many people haven't asked what the objective of case management is. That objective may change depending on what contracts the hospital has with various payers.

Everyone working in a hospital has to understand how the business runs, Burgess says. "The fantasy that managed care is going away is a fallacy, but it's going to continue to modify considerably. Managed care is fully implemented at the executive level, but in lots of cases, people at that level haven't done a very good job integrating managed care with the clinical side. As a result, managed care becomes a financial model, not a clinical one." If the executive group administering managed care contracts is communicating with the clinical group regarding the parameters the hospital has to work within and what it costs to keep the organization afloat — including case management — how can the clinical side know what's going on?

Case managers need to know what drives the hospital and what keeps it open, experts say. They have to understand how their facilities get paid and the level of contracts in their hospital — whether they are cost-based or revenue-based. They need to know that if care is capitated, that's a cost-based contract and the hospital receives a flat monthly fee for each health plan member. Everything they do for a patient takes money out of the hospital's coffers.

On the other hand, "A lot of hospitals still have revenue-based, or per diem, contracts, especially in the Midwest," says Burgess. Often, those contracts are either front-loaded, meaning the more intensive days are in the beginning, or flat. "The

As managed care evolves, CM adapts to changes

CMs address patient needs throughout system

The impact of managed care has already reached Affinity Health System in Wisconsin, where case managers had to struggle with the question of whether they should be specialists or generalists and how much direct involvement they should have in dealing with managed care companies.

Jean Russell, vice president of health management with Network Health Plan, says Affinity had a case recently that called into question how to take assignments at her facility. "There's a lot of emphasis on discharge planning for case managers. Shouldn't it be the role of the hospital case manager to work with the payer's case manager on a patient in the community who's left the hospital? Shouldn't it be her role to keep that patient at an optimum health care level?" Russell says her vision is for those patients to be assigned the same case manager when they are admitted to the hospital. "I think assignments should be made that way, rather than based on cardiac or orthopedic factors."

"This is an evolutionary period in managed care," says Russell, who works with Mercy Medical Center in Oshkosh and St. Elizabeth Hospital in Appleton, both part of Affinity. "As it evolves, our case management efforts need to evolve with it. In one of our hospitals, for example, we've assigned one of the case managers to the emergency department."

She says a part of their vision is that when the acute care section of the hospital is not the appropriate level of care for a patient, they address the patient's needs at whatever level is most appropriate. "And sometimes that's right there in the ED. People sometimes go to the emergency department for reasons that are not emergent. Our case manager there triages the people not needing acute emergency care." She says her team sees that move away from the general hospital as leading to a community-based case management program. "We're hoping to follow up ED cases and really provide the optimum in a seamless system of care."

She says Affinity is working on some population-based programs. A task force at the organization is planning to help seniors by hosting social events at which activities more substantial than socializing take place. "We can present programs that provide legal advice and do mini health assessments," says Russell. "For example, we'll try to find congestive heart failure patients early and get them to treatment in an ambulatory setting. I see case managers moving toward more roles like those." Affinity also is working on a systemwide diabetes program.

A high-risk pregnancy program called "Baby and Me" will be implemented systemwide by November. "We used case managers from the health plan to manage the high-risk cases, but now I have responsibility for deciding who is going to manage the cases that are not health plan but are within the Affinity Health System population," Russell says. "There will always be a need for individual case managers, but there's an evolution to merge their functions with quality and utilization functions."

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hospital may not get as much as it used to, but it still gets paid for every day and everything done."

For example, says Burgess, if a unit decided to try to cut its length of stay (LOS) from seven days to three and the case manager there didn't understand the payment mechanism in her hospital, that cut in days could cut the revenue flow for the hospital.

McCarthy says he knows of a large urban hospital where if diligent case management had resulted in a decreased LOS of one day, the institution would have lost $18 million per year because most of the hospital's contracts were per diem.

"The category of hospital where that would be true is one where a large percentage of payers are per diem and where the hospital doesn't have 100% occupancy," says McCarthy. How would you case-manage in that scenario? How do you handle cases that are fee for service, compared to cases that are per diem, compared to capitated patients, compared to cases that are

case-rated — where the payer pays a certain amount for a specific type of case no matter what the LOS is?

"All these different forms of payment exist," says Vernick, "and the goal of case management needs to be clearly delineated before you manage yourself out of business." You cannot treat patients differently depending on payment class, but you might select certain groups for case management.

> "Knowing what's going on on the business side may change the order in which case managers plan care."

"You might want to say, 'We're going to case-manage our DRG patients, but we're not going to case-manage our per diem patients, because the case management of our per diem patients might result in a decreased LOS, depending on the occupancy rate of the hospital,'" says McCarthy.

"Many think that nurses and case managers shouldn't talk about money, because that's not their job," says Burgess. "But they do have to know the business and what the incentives are." For example, they have to know whether the facility is on a per diem plan. They have to know how to prioritize care and provide the patient with days in the hospital when he cannot be anywhere else — when his medical care is complex and he requires 24-hour nursing care. After that, the patient can be placed in the continuum.

"Knowing what's going on on the business side may change the order in which case managers plan care," says Burgess. Then they can ask: What does the patient need, given the resources available — medical stabilization? An adjustment in medications? What does he or she need to do to move to the next level of care? As part of the facility's managed care contract, the insurance company case manager may have said, "You've got 12 days to do that." If the case manager doesn't know that and hasn't prioritized care, her patient could be discharged before the program is finished.

Burgess says that happens often. "A patient can learn to dress and bathe himself later on in a much less costly level of care. He doesn't need to be in a hospital to do that. If the only reason he can't go home is that he can't feed himself and there's no one at home to help him, the case manager needs to know what that insurance company case manager said — how many days they have in the hospital to work on that."

She points out that a lot of staffs are angry with managed care. "We need to replace that anger with information and knowledge so they can make better decisions through understanding what's going on." If the clinical staff were more informed about how to work within a managed care environment, she says, they could be contributing more to stronger clinical models and better quality care within the limited financial parameters. But the way things are now, many can't think critically about managed care because they don't understand it. No matter how many contracts an executive team negotiates, if the people delivering the care don't understand how the payment system works, they can get an institution in trouble quickly, not out of any deliberate intent but because they don't understand what's going on.

Has managed care been a failure? "No," says Burgess. "It has raised awareness and saved many dollars. But it hasn't saved as much as we anticipated and has not done everything we hoped it would." She says most HMOs are having to raise their rates on benefits packages by 8% to 9%, and employers — particularly the small ones — are struggling with the cost of running their employees' health care benefits and for the most part are having to regroup. "Employers are starting to say with louder voices, 'This isn't working for us.'" She predicts we're beginning to see the demise of capitation.

"But I'd never abandon managed care as hopeless," says Burgess. "It has brought about many innovations, and one of the biggest has to do with prevention. Because of its efforts, there's now a national surge among consumers toward wellness and prevention."

(Editor's note: In next month's installment of our series on managed care, you'll read about changes looming in the managed care arena and about how one facility's case management department was completely eliminated due to managed care pressures.)

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AMBULATORY CARE
QUARTERLY

Prevention program cut patient falls by 10%

Help patients overcome their fears, complacency

In the past few years, falls have killed 7,000 to 12,000 people over age 65. Nearly one-third of older Americans fall, costing more than $20 billion in direct health care costs, according to the U.S. Department of Health and Human Services. Elderly people who have chronic or serious health problems, including conditions that require rehabilitation, are at even greater risk of falling and becoming injured.

"We recognize falling as a potentially serious problem for our patients, and it's a common occurrence in rehab because what we're trying to do is get patients as close to an independent level of functioning as possible," says **Dorothy Doweiko**, RN, director of quality management for Spaulding Rehabilitation Hospital in Boston. Spaulding has about 290 beds and an outpatient program and is affiliated with Massachusetts General Hospital and Brigham and Women's Hospital, also in Boston.

Here's an example of a common falling scenario: A physical therapist and occupational therapist work to maximize a patient's functioning during therapeutic sessions. Eventually, the patient regains self-confidence and some independence. One day after therapy sessions, the patient is back in the room and decides to get up and move without assistance. Then the patient falls.

"We try to set limits for when patients are back in their rooms, but many times patients don't take the advice of their therapist or nurse, and they try to get up to go to the bathroom independently, and that's when they fall," Doweiko says.

Spaulding Rehabilitation Hospital has had a 10% decrease in the number of falls over the past three years, a result of the hospital's comprehensive fall prevention program. The hospital made a number of changes in the way it dealt with falls and the way staff evaluated patients for the risk of falling. Here's how the program works:

1. The hospital formed a fall prevention task force. First, hospital administrators decided to make fall prevention a priority. "It was our No. 1 problem on the incidence reports," Doweiko says. Then employees and managers formed a fall prevention task force, which worked with the quality management department to develop strategies related to reducing falls.

The task force first had to define the term "fall." "There are different definitions for falls, and when you read articles about patient falls, some institutions categorize a fall as when a patient hits the floor involuntarily, even when the patient is dizzy and assisted to the floor by a therapist," Doweiko explains. "That's a situation where the patient is aware of what's going on, and for the most part, the patient is not injured." The task force decided not to include that type of situation in its definition of a fall. Instead, it defined the term as an incident in which a patient hits the floor involuntarily and unassisted. Then task force members outlined strategies for reducing the number of falls and developed an interdisciplinary fall risk prevention policy.

2. Staff collected data on patient falls. The quality management department had been collecting fall data over several years, so the task force used the information as a baseline for measuring improvement.

Employees routinely fill out incident reports that include falls, and the task force and quality management department pulled all the reports relating to patient falls. Then they collected the information on a database and analyzed it for trends. "We tried to categorize different types of falls," Doweiko says. Those situations include falls that occur when a patient is trying to get to the bathroom or when a patient moves to or from a shower chair.

3. They gave staff a risk assessment tool. The task force researched risk assessment in current

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CRITICAL PATH NETWORK™

Practice guideline tackles fall risk

Medical Directors' algorithm aids risk assessment

The American Medical Directors Association in Columbia, MD, and the American Health Care Association in Washington, DC, have developed an algorithm and clinical practice guideline on patient falls. **(See algorithm and fall risk checklist, pp. 40-42.)** These tools are intended to guide caregivers in assessing and managing individuals who have a recent history of falls or who are at risk. The guideline is relevant for any situation, whether aggressive or more limited care is desired.

Conditions representing risk factors for falls include:

- previous falls, fear of falling, history of fractures;
- cardiac arrhythmias, transient ischemic attacks, stroke;
- Parkinson's disease;
- delirium, dementing illnesses, depression, acute and subacute medical illnesses;
- musculoskeletal conditions such as myopathy and deformities, problems with mobility or gait;
- orthostatic hypotension, dehydration, hypoglycemia;
- incontinence of bowel or bladder;
- visual or auditory impairment, dizziness;
- use of restraints;
- polypharmacy.

Medication categories commonly associated with injury from falling include:

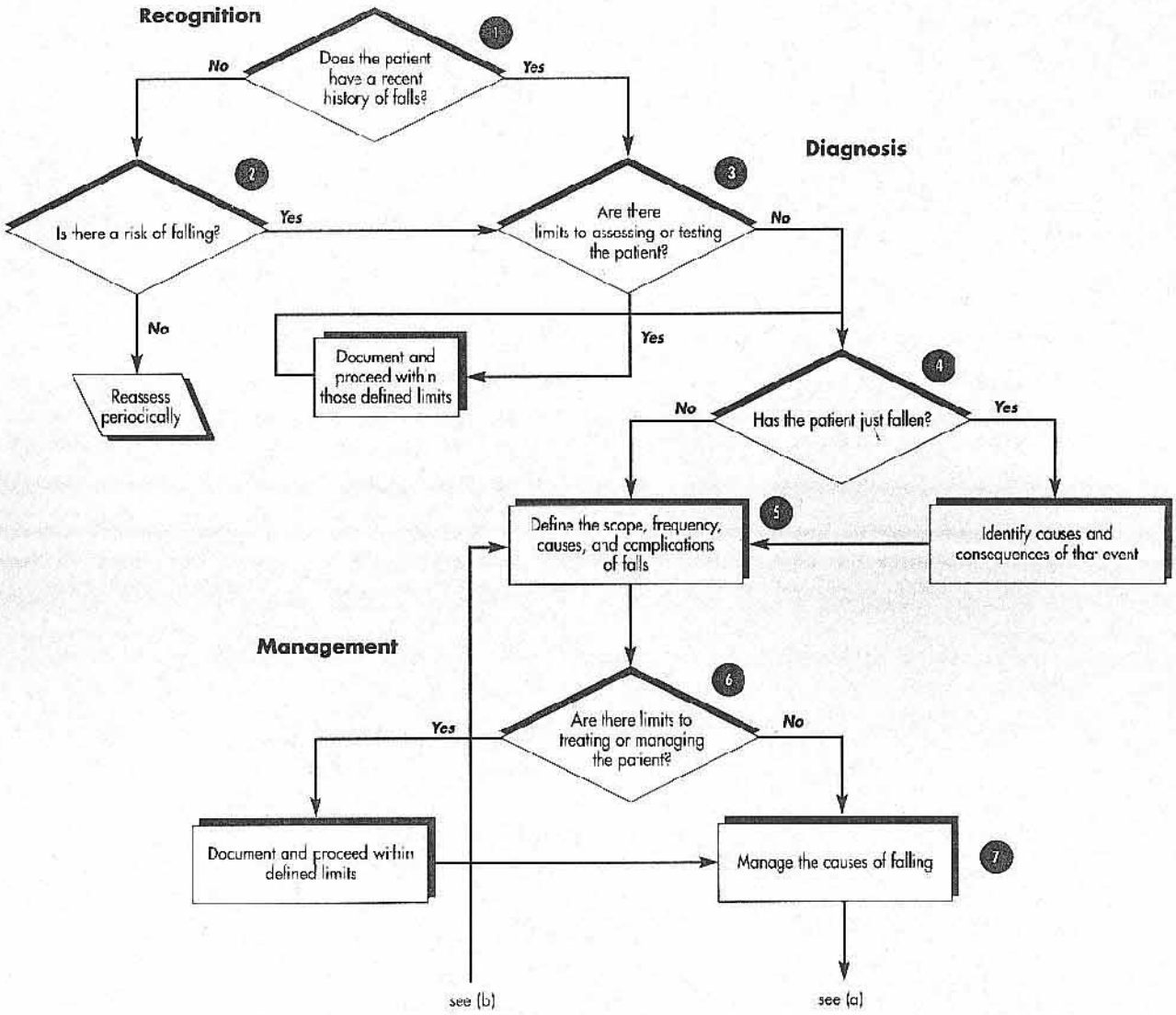
- anticoagulants, antidepressants, antiepileptics, antihypertensives, anti-Parkinsonian agents, vasodilators;
- benzodiazepines, diuretics, narcotic analgesics, nonsteroidal anti-inflammatory agents (NSAIDS), psychotropics.

Complications from falling include:

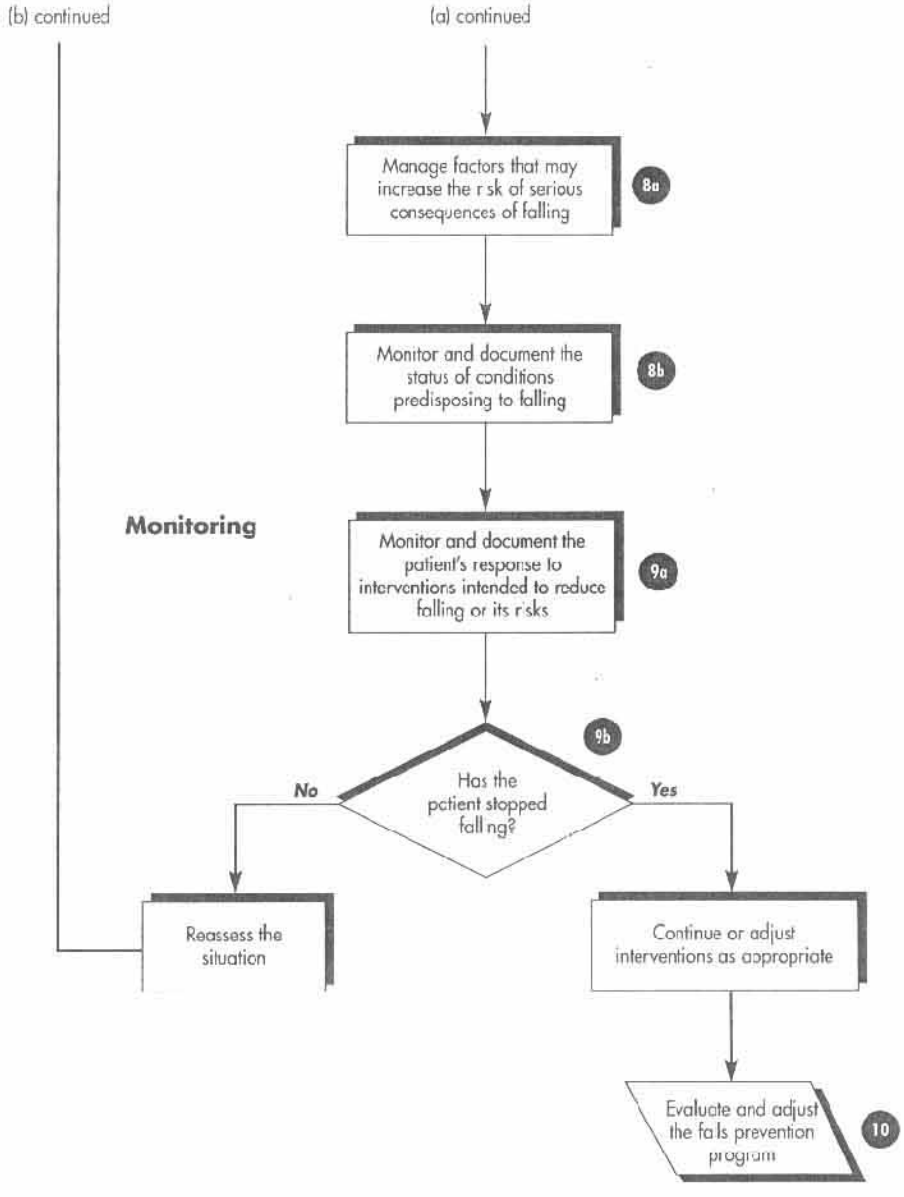
- abrasions, contusions, lacerations, ecchymosis, hemorrhage;
- anemia;
- concussion, subdural hematoma;
- fracture, sprain, or dislocation;
- fear of falling resulting in loss of confidence, decreased independence, and social isolation.

Environmental factors associated with falling include:

- dim lighting, glare;
- poor or weak seating;
- use of full-length side rails, inadequate assist devices;
- inappropriate footwear, poorly fitting eyewear;
- uneven flooring, loose carpet, wet slippery floor;
- lack of safety railings or bathroom grab bars;
- malfunctioning emergency call systems;
- poorly positioned storage areas.



Source: American Medical Directors Association, Columbia, MD.



Source. American Medical Directors Association, Columbia, MD.

Checklist for Assessing Fall Risk and Post-fall Review

Factors	Fall risk	After a fall
Falls history	❑ Review history of previous falls	❑ Review history of previous falls
Underlying illnesses and problems	❑ Assess for presence of underlying medical condition that predispose to falls ❑ Assess for presence of orthostatic hypotension and conditions predisposing to it ❑ Assess for presence of underlying medical conditions affecting balance, causing dizziness or vertigo ❑ Assess for presence of underlying medical conditions that increase injury risk from falls	❑ Review the status of any medical conditions that predispose to falls ❑ Assess for presence of orthostatic hypotension and manage predisposing conditions ❑ Review status of any underlying medical conditions affecting balance, causing dizziness or vertigo ❑ Assess status of underlying medical conditions that increase injury risk from falls
Medications	❑ Review for medications that could predispose to falls; especially diuretics, cardiovascular medications, anti-hypertensives, antipsychotics, antianxiety agents, sleeping medications, antidepressants ❑ Reduce dosages or eliminate such medications	❑ Review for presence of medications that could predispose to falls; adjust dosage or stop medication as indicated ❑ Review for recent changes in medication regimen
Functional status	❑ Review for impaired mobility, standing or sitting balance ❑ Review for impaired ability to use ambulatory assistive device (cane, walker, etc.) ❑ Review situation related to restraints ❑ Review activity tolerance, possible deconditioning ❑ Review bowel and bladder continence status ❑ Assess footwear utilization	❑ Reassess mobility, standing and sitting balance ❑ Reassess use of ambulatory assistive device (cane, walker, etc.), modify as indicated ❑ Review situation related to restraints ❑ Review activity tolerance, possible deconditioning ❑ Review bowel and bladder continence status ❑ Assess footwear used at time of fall
Sensory status	❑ Look for conditions (cataracts, glaucoma, macular degeneration) reducing vision	❑ Review status of conditions affecting vision ❑ Reassess visual and auditory impairments
Psychological status	❑ Assess for presence of depression ❑ Review for impaired cognition, judgment, memory, safety awareness, decision-making capacity	❑ Assess for symptoms of depression ❑ Reassess cognition, judgment, memory, safety awareness, decision-making capacity as indicated
Environmental status	❑ Assess for environmental factors that could cause or contribute to falls	❑ Review and modify environmental factors that could have caused or contributed to fall

Source: American Medical Directors Association, Columbia, MD.

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medical literature and then helped create a one-page risk assessment tool for identifying high-risk patient behaviors. The tool includes general data, such as the patient's age and whether he or she has a history of falls. The tool has categories that describe the patient's physical condition, ambulatory devices used, medications prescribed, and mental status.

Each item has a place for nurses to check if the item applies to a particular patient. Once the nurse has completed the risk assessment tool, the checkmarks are evaluated. When the tool has four or more checkmarks, the patient is labeled high risk for falling.

Assessment tool needed to be revised

The first version of the risk assessment tool placed patients in categories of low, moderate, and high risk. But the tool didn't work as expected. The tool was good at identifying low-risk patients who didn't require fall prevention education and extra assistance, and it could identify high-risk patients who were given extra education and interventions and therefore had fewer than predicted falls. The problem was that patients in the moderate category became part of a gray area. They didn't receive as much attention as the high-risk patients, which led to an unacceptable fall rate.

"The patients who were assessed to be at moderate risk were the ones who were falling the most," Doweiko notes. "They were the ones who were really our most frequent fallers."

The task force revised risk assessment. Now the tool has only two categories: low risk and high risk. Patients who previously were considered at moderate risk now receive the same education and interventions as those who are at high risk.

The tool also lists the interventions clinicians may choose, and it has a place to record when each intervention began. Interventions vary according to the patient's condition. The risk assessment tool for traumatic brain injury patients will be slightly different from the tool used for cardiac or respiratory patients, for instance.

Here are some examples of interventions:

- ensuring a nursing call light is within the patient's reach at all times and that nurses answer it as soon as possible;
- encouraging families to provide sneakers or other types of nonskid footwear for patients;
- putting the bed in a low position;
- keeping the patient's transfer status up to date on the communication board in the patient's room;
- making sure the patient is not left unattended during transfers or when walking.

Clinicians complete the assessment tool for each patient each week, noting any changes in status, such as if the patient has had a fall or appears to be unstable.

"It's because we take the tool so seriously that we have good outcomes," Doweiko says. "It takes everybody being cognizant of the potential problems if we're not mindful of a safe environment for each patient."

4. The task force educated staff, patients, and families. First, the hospital started a large educational effort, sending representatives to each floor to talk about different types of fall prevention measures that could be used for specific patient populations. For example, patients who have had strokes will need different fall prevention interventions from patients who have had a spinal cord injury.

Task force members and quality managers even visited the night shift staff, bringing doughnuts to 2 a.m. and 3 a.m. educational sessions. The education included showing employees videos with realistic scenarios that displayed problems resulting in falls. "The videos provoked discussion," Doweiko says. "One video gave a case study of how an employee should handle a patient who is obviously not safe, and it discusses the interventions the staff could take."

Each month, the hospital posts 12 fall prevention posters in corridors where they can be seen easily by staff, patients, and patients' families. Therapy and nursing clinical educators created the posters using computer graphics, and the hospital printed them. Then the posters were laminated and hung on the walls. Each poster highlights a different issue related to falls and fall prevention, and they're changed monthly.

"We want families to participate in this need for safety awareness, so the posters have common-sense guidelines," she explains.

Staff education included brown-bag luncheon discussions about fall prevention. The task force gave each floor or program some data about their own fall trends. "It's really critical for the staff to know how they are doing," Doweiko says.

The task force also showed employees a comparison of the hospital's fall data with fall data from other area hospitals. Unfortunately, the only

data Doweiko could find for comparison came from acute care hospitals, so the comparison isn't a true benchmark. "But at least they can see where we fit in when compared to acute care hospitals," she adds.

The comprehensive educational campaign paid off. Employees began to contribute their ideas and observations, and this helped the task force create more specific and better interventions. For instance, some staff said their problem wasn't so much that patients weren't following directions. Instead, most patients were on diuretics, which caused them to urinate frequently. Because those patients often were getting out of bed alone during the night and risked falling, the task force took appropriate steps, like placing commodes at the patients' bedsides.

For more information, contact Dorothy Doweiko, RN, Director of Quality Management, Spaulding Rehabilitation Hospital, 125 Nashua St., Boston, MA 02114. Telephone: (617) 573-2475. Web site: spauldingrehab.org. ■

Help patients recover from the fear of falling

It can hinder independence, recovery

Sometimes therapists find it difficult to motivate elderly patients to regain their strength and mobility after an accident or surgery. Patient recovery may lag behind for many reasons, but one potential cause might surprise clinicians: Patients may be afraid they will fall.

Elizabeth Walker Peterson, MPH, OTR/L, first became intrigued with the idea that a fear of falling is a disability after observing older people who had taken serious falls. "I noticed it was difficult to motivate people to participate in therapy in the hospital because they were very concerned about falling again," says Peterson, who is a clinical assistant professor at the University of Illinois at Chicago. "Fear of falling is a rational response to an event that could conceivably happen to them, and even people who haven't had a fall have a fear of falling," she says. "If the fear is intense enough, it can lead to activity restriction, and then you get into the vicious cycle of activity curtailment and deconditioning caused by the fear of falling."

Peterson was among researchers at Boston University School of Public Health, the University of Illinois at Chicago, and several other universities who participated in a randomized, controlled trial that sought to reduce the fear of falling among older adults.

The research led to the development of a program called "A Matter of Balance," which teaches patients greater control and instills confidence in their abilities with the purpose of eliminating their fears of falling. The program provides a group intervention in which participants are taught better communication skills and physical exercises and are given an opportunity to gain insight into their own fear and the actual risk factors of falling. Here's an outline of how the fear of falling program works:

- **Create a structured group intervention.** Older adults meet as a group partly because some parts of the education are interactive and work better in a group setting and partly because the participants give each other support, which has a therapeutic effect.
- **Focus on cognitive restructuring.** Program leaders try to change attitudes about falling, partly through the use of skills training in fall prevention and presenting facts about the incidence of falls and what to do if one falls.
- **Provide exercise training.** The program emphasizes how exercise and strength-building help reduce the risk of falling.
- **Use a group to build social support.** By providing a group setting, facilitators give participants an opportunity to share their concerns with others who have had the same experiences, serving as a support network.
- **Teach assertive communication skills.** Older adults often do not know the difference between assertive, aggressive, and passive behaviors, Peterson says. "This is relevant to fall prevention because older adults may be placing themselves at risk when they're not assertive."
- **Educate about environmental hazards.** The program teaches participants who live in their own homes within an assisted-living facility or on their own about physical hazards in the home, such as living room extension cords or phone cords that trail across a floor.

For more information, contact Elizabeth Walker Peterson, MPH, OTR/L, Clinical Assistant Professor, University of Illinois at Chicago, Department of Occupational Therapy, 1919 W. Taylor St., Chicago, IL 60612. Telephone: (312) 996-4506. ■

Clip these tips to reduce falls and eliminate fear

Strategy reduces risk, concerns

Falls cause serious injuries, health problems, and fatalities in elderly people, and the fear of falling can lead to social isolation and physical deconditioning as people try to avoid physical exertion that might cause a fall.

Rehabilitation providers and other health care professionals can help their patients reduce the risk of falling and eliminate their fears through interventions and special programs, says **Elizabeth Walker Peterson**, MPH, OTR/L, clinical assistant professor at the University of Illinois at Chicago.

One strategy would be to give patients these handy guidelines Peterson has created, which are designed to help people reduce the risk of falls and conquer their fear of falling.

How to Reduce the Risk of Falls

- **Take charge:** Talk to your health care providers to identify your risk factors for falls.
- **Get involved:** Take an active role in creating fall prevention strategies that fit your needs, lifestyle, and goals. If, for instance, you still are storing food and other items on high shelves, you may want to consider asking someone to help you bring everything down so you aren't reaching up for things, even infrequently.
- **Remember:** Unless you are satisfied with a plan to reduce the risk of falling, it is unlikely that you will follow through with it.
- **Prioritize:** Falls often are caused by many factors and may require a variety of prevention efforts, such as reducing the number of prescription medications, changing positions slowly to avoid a drop in blood pressure, and installing grab-bars by the toilet. Once you've learned what your fall risk factors are, decide which ones you want to address first. Consider which change is the easiest to make and which will have the greatest positive impact on your health. Success in eliminating one risk factor will motivate you to continue your efforts.
- **Exercise:** Exercises that improve balance, such as Tai Chi, have been shown to reduce fall risk. Talk with your doctor and explore community resources to find an exercise program that will work for you. You can gain the support you need to stick with an exercise program by exercising with a friend.
- **Be assertive:** Make requests — for a seat on a crowded bus, for example, or to have a dangerous throw rug removed. Everyone needs advice and assistance from time to time. Such requests are a way to help you avoid a fall and maintain independence.
- **Have a contingency plan:** Know what you will do should you fall when you are alone. Find out from your health care provider about the best way to get up after a fall, and have a plan for reaching help. Also, ask someone to routinely check on you to ensure your safety.

How to Reduce Concerns about Falls

- **Acknowledge your concerns:** Your concerns about falling are a rational response to a real threat to your independence, and many older adults share this concern. Being aware of your concerns about falls and how they affect your physical or emotional health is the first step in managing the fear of falling.
- **Explore your attitudes:** Negative attitudes about aging and fall prevention, such as "exercise is dangerous at my age," block your desire and ability to take positive steps to prevent falls. Positive thoughts, on the other hand, inspire action.
- **Practice, practice, practice:** To gain confidence in your abilities to reduce fall risks, you will need to prove to yourself that you have the necessary skills. These skills vary depending on your unique fall risk factors. Common skills used to prevent falls include exercising regularly, communicating assertively, and finding alternatives to potentially risky behaviors.
- **Be a problem solver:** Set goals and create action plans. Identify potential barriers to accomplishing goals and address those threats to your success. Remember that needs change over time, so re-evaluate your fall risk factors, goals, and action plans regularly. ■

NEWS BRIEFS

Albumin may increase mortality, study finds

Human albumin is often given to ICU patients with life-threatening hypovolemia because its high osmotic pressure will help retain fluid in the patient's vascular system. A recent British review of 30 trials (1,400 patients in all) shows, however, that its administration increases mortality.[1] There were on average six extra deaths for every 100 patients treated with albumin. The reasons are unclear, but the investigators propose these possibilities:

- Pulmonary edema can occur suddenly due to rapid volume expansion with albumin, even in hemorrhagic shock.
- The capillaries of seriously ill patients often become more permeable to albumin, and the addition may worsen interstitial edema.
- Albumin has anti-hemostatic and platelet-lowering properties and may increase blood loss in postsurgical and trauma patients.

Reference

1. Cochrane Injuries Group Reviewers. Human albumin administration in critically ill patients: Systematic review of randomized controlled trials. *BMJ* 1998; 317:235-240. ▼

Day 'carve-outs' move east

If you live and work on the East Coast, you may soon see managed care companies crack down on what they consider long lengths of stay in a new way: by refusing to pay for avoidable days, such as that first day or evening when the patient has a shower, a complete blood count, a urinalysis, and a chest X-ray. All of those could be done in a less acute setting, explains **Joel Mattison**, MD, physician advisor for St. Joseph's Hospital in Tampa, FL.

While insurers in California have been carving out days for years, the 'day carve-outs' are now affecting New York hospitals, according to an Oct. 19, 1999, *New York Times* report. Three years ago, hospitals in New York state received reimbursement based on diagnosis, not on the number of days a patient spent in the hospital. Day carve-outs accounted for only about 5% a year ago, but over the past nine months, they have accounted for up to a third of days submitted. In most cases, insurers will deny payment for the last night of a patient stay, but the practice also can apply to one or more mid-stay days if the insurers "deem that the time was spent inefficiently," according to the report.

Because the costs from denied days cannot by law be transferred to patients, this new tactic can put a paperwork burden on you as well as cut into hospital profits. One "avoidable" day can represent a loss of income for the hospital that is greater than the current Medicaid per diem of $812, says Mattison. The *New York Times* report states that the Greater New York Hospital Association has asked the state Attorney General's office to investigate the carve-out practice.

For more information, contact Joel Mattison, MD, physician advisor, Department of Utilization Management and Quality Assurance, St. Joseph's Hospital, Tampa, FL. Telephone: (813) 870-4933. E-mail: jmat1933@aol.com. ▼

Amputation rates rising among older Americans

Older Americans with advanced low-extremity vascular disease are at increased risk of leg or foot amputation, reports a recent study out of Northwestern University in Evanston, IL.[1]

According to the investigators, the increase is the result of three factors: prevalence of diabetes, hospitals' declining capacity to perform lower-extremity bypass surgery and angioplasty, and increased longevity of patients with cardiovascular disease. The team looked at rates of amputation procedures between 1979 and 1996 and found that rising rates at the beginning of the study period were reversed following introduction in the early 1980s of procedures for dilating or bypassing blocked leg arteries. By the mid-1990s, however, the trend began rising again. By 1996 the combined rates for above- and below-knee amputations were 11% higher than they had been in 1979.

Reference

1. Feinglass J, Brown JL, LoSasso A, et al. Rates of lower extremity amputation and arterial reconstruction in the United States. *J Am Publ Health Assoc* 1999; 89:1222-1227. ▼

Guidelines not guiding as well as hoped

Patients are not receiving the care recommended in clinical guidelines, according to a recent nationwide study conducted by The Medstat Group, a division of Thomson Healthcare in Ann Arbor, MI. Investigators compared care actually received to care recommended for individuals with asthma, diabetes, and heart failure. Results revealed a significant gap between what is recommended by leading health care organizations and what actually occurs.

Nearly 16,000 diabetics were followed. Only 29% received an annual eye exam and only 46% received an annual total cholesterol test, both of which are recommended by the Alexandria, VA-based American Diabetes Association. Those rates are significantly below expectations. "While we might not expect 100% of patients to receive the care recommended, we must certainly expect most patients to receive it," says **Louis H. Diamond**, MD, vice president and medical director at The Medstat Group.

The study also showed that care delivered to individuals with heart failure varies significantly compared to what is recommended:

• Of nearly 4,000 heart failure patients, only 40% received an echocardiography within three months of their initial diagnosis, despite its recommendation by the Agency for Health Care Policy and Research.

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• Of about 2,500 heart failure patients, only 46% received a chest X-ray — recommended by the American Board of Family Practice — during the 12-month period following diagnosis.

• In addition, a review of about 6,500 asthma cases showed that only 27% received an inhaled anti-inflammatory drug as recommended by the National Heart, Lung and Blood Institute. ▼

Perinatal ZDV: No silver bullet for HIV infants

Five years ago, investigators in the ACTG 076 trial reported in the *New England Journal of Medicine* that perinatal zidovudine (ZDV) treatment of HIV-infected pregnant women reduced transmission of HIV to their infants from 22.6% to 7.6%. The women received ZDV or placebo during pregnancy and labor, and their infants received ZDV or placebo for six weeks. The protocol was implemented nationally, and there was a major decline in childhood AIDS.

A new report has been published by investigators from New Jersey Medical School in Newark, NJ, about the infants who became infected while they and their mothers received ZDV preventive therapy or placebo in the ACTG 076 trial.[1] The researchers set out to describe the effect of ZDV on the course of disease. There were 14 in the treatment group and 43 in the placebo group. Median birth weights, gestational age, and maternal viral load at delivery were similar in each group. The investigators followed the babies for up to age 78 weeks or death. They assessed the development of genotypic ZDV resistance among the infants in the treatment group.

Progression of HIV disease did not differ significantly between the two groups. Both had the same proportion of viral isolates resistant to ZDV. The perinatal ZDV did not appear to affect the course of infection; it failed to have a major effect on rapid progression of disease, timing of transmission, and viral replication in HIV-infected infants. When the ZDV regimen failed to prevent maternal-infant transmission of HIV, resistance to ZDV did not develop during study treatment. The investigators report, "Our study supports the safety of zidovudine use in pregnancy and in the newborn period but demonstrates the continued need for more potent antiretroviral treatment of the infected infant."

Reference

1. McSherry GD, Shapiro DE, Coombs RW, et al. The effects of zidovudine in the subset of infants infected with human immunodeficiency virus type-1. *J Pediatr* 1999; 134: 717-724. ■

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. ■