HOSPITAL CASE MANAGEMENT™

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

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Case managers likely to play big role in pay-for-performance initiatives

Hospital pay-for-performance measures being tested by CMS

Sometime in the next few years, your hospital could receive some of its Medicare reimbursement based on how well it performs, if the Centers for Medicare & Medicaid Services (CMS) follows its typical course of action.

Hospitals are advised to start preparing now for future pay-for-performance initiatives from CMS, initiatives in which case managers should play a major role, says **Teresa Fugate**, RN, BBA, CPHQ, CCM, manager with Pershing, Yoakley & Associates, a Knoxville, TN-based health care consulting firm.

"There is likely to be an incentive to care for your patients more efficiently and more effectively. If the demonstration project proves to be successful, CMS will roll it out for all hospitals," she says.

The CMS Hospital Quality Incentive Demonstration Project, launched October 2003, is the first national test by Medicare to analyze the impact of economic incentives on quality care.

CMS contracted with 278 hospitals that subscribe to Premier Inc.'s clinical benchmarking system, Perspective. Premier Inc. in San Diego is a health care alliance that helps hospitals improve clinical and financial performance with comparative data, supply chain management, and insurance services. The project involves 34 indicators in heart attack, coronary artery bypass graft, heart failure, community-acquired pneumonia, and hip and knee replacement.

The quality measures include all 10 indicators from the National Voluntary Hospital Reporting Initiative and indicators from National Quality Forum, CMS 7th Scope of Work Indicators, Joint Commission on Accreditation of Healthcare Organizations Core Measures Indicators, Leapfrog Group indicators, and Agency for Healthcare Research and Quality patient safety indicators. **(For a list of indicators, see chart, p. 133.)**

The five clinical areas chosen for the demonstration project are the top

diagnosis-related groups (DRGs) for which Medicare is billed.

The CMS project does not look at cost. It examines key processes, such as prompt administration of beta-blockers and antibiotics as well as a few key outcomes, such as mortality rate and hospital readmissions.

Hospitals participating in the demonstration project will be eligible for increased Medicare payments in each of the five clinical areas if they are among the top performers in a given area. The top 10% in each clinical area will receive a 2% increase in Medicare payments. The next 10% receive a 1% increase.

The bonuses are expected to total about $21 million during the three-year pilot project.

In the third year of the project, hospitals that fail to improve their performance in a specific clinical area beyond a minimum threshold established in the first year of the project will be subject to a payment reduction of 1% or 2%.

The pay-for-performance arrangement is a win-win situation for Medicare, Fugate points out. If hospitals improve the quality of care for their patients, they're naturally going to decrease their costs, she adds.

The 278 hospitals in the pay-for performance project submit data to Premier, where they are aggregated and examined for data integrity.

Premier works with the individual hospitals on ways to improve their performance, says **Jan McNeilly**, RN,CPHQ, CHE, principal for clinical advisor services at Premier. "The hospitals in the project are motivated to look at performance improvement in a different way. They can't spend 12 to 18 months on a performance improvement project. They have to think about rapid cycle improvement," she says.

Even before the demonstration project, Premier was tracking clinical performance from its member hospitals and others who contract for Premier's services, McNeilly adds.

The organization has a comparative database with inpatient data from more than 500 hospitals, some of which contract with Premier for their consulting services. The data include the entire billing and medical record file for inpatient discharges. The majority of the hospitals also submit data from outpatient services.

"The data we collect are comprehensive. For every discharged patient, we know their diagnosis, any secondary diagnoses, everything billed to them, what time they spent in the ICU [intensive care unit], what kinds of antibiotics they were prescribed," McNeilly explains.

The Premier staff use the data to determine which hospitals are the best performers and to share knowledge about what the best performers are doing to help other hospitals.

Premier always has calculated the top quartile

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set of hospitals based on the clinical processes, outcomes, and costs. There is a separate one for each key condition. When the demonstration project started, the hospitals in Premier's database already were exceeding national norms on key measures.

"The demonstration project gives us another best-in-class kind of comparison," McNeilly says.

Premier uses the 3M APR-DRG system to adjust the data.

"The staff and management at every hospital I visit tell me, 'Our patients are sicker,' but when we examine the data for pneumonia, for instance, the data rarely validate their perception," she adds.

When Premier works with its hospitals to improve their clinical quality, the staff always work with the case management staff, McNeilly says. "The CMS pay-for-performance project has added another layer to the case managers' responsibilities. In addition to making sure the hospital is using its resources wisely and that unnecessary delays are not occurring, the case managers are now working to ensure that the right things are being done," she notes.

Case managers in the participating hospital are taking a stronger role on the care planning team to make sure the patients receive the recommended care in a timely manner, McNeilly says.

"The case management staff is growing. I'm going into hospitals where they have 20 to 30 case managers with roles that have expanded far beyond the traditional utilization review role," she adds. For instance, some hospitals have set up call centers where staff have the responsibility to work with the insurance companies, freeing up the case managers to spend more time with the patients.

"Case managers are clearly a member of the team that is coordinating care, rather than someone policing the length of stay," McNeilly says. In other hospitals, there are case managers who are dedicated to a particular population, such as congestive heart failure, and coordinate both inpatient and outpatient follow-up, she adds.

Contracts with hospitals that subscribe to the comparative database include performance improvement and infrastructure assessment.

"We look at how embedded is quality improvement in this organization? Do they actually focus on quality or just on meeting the JCAHO standards for performance improvement?" McNeilly says.

She examines how engaged the senior executives are in performance improvement.

In some hospitals, the management merely delegates performance improvement and is not directly leading the program. In others, senior management is heavily involved.

For instance, at one of the top performing hospitals, when McNeilly asked about quality indicators, the chief financial officer described what they did to improve patient aspirin compliance for stroke patients.

The demonstration project offers an opportunity for all hospitals to benefit from what participating hospitals learn, Fugate adds.

"There is an inherent need for the hospitals to improve quality. These indicators have been shown to improve the quality of patient care. It's evidence-based medicine, and they should be doing it anyway," she says. ■

Case managers can lead the way in P4P initiatives

Start by identifying your top DRGs

Case managers will be invaluable to their hospitals if the Centers for Medicare & Medicaid Services (CMS) institutes pay-for-performance measures for all hospitals, **Teresa Fugate**, RN, BBA, CPHQ, CCM, asserts.

"Case managers are so important in this effort because they are in there conducting concurrent review based on standards of care. Their bottom line is to merge the clinical and financial and understand how improvement in quality of care can impact reimbursement," says Fugate, manager with Pershing, Yoakley & Associates, a Knoxville, TN-based health care consulting firm.

The key in hospitals is to start by identifying your top DRGs. Most are likely to be related to CMS indicators, she adds.

Fugate recommends that hospitals start concentrating on the CMS indicators. Instead of collecting the data retrospectively, they should be monitoring them concurrently. "If you collect data only retrospectively, you have lost the ability to intervene and affect the outcomes," she says.

"It's important to align case management, performance improvement activities, and quality improvement activities," Fugate explains.

Incorporate the quality measures for the targeted DRGs in your case management activities. Make sure the interventions occur in a timely

fashion. If it doesn't happen, intervene with the physicians and get them to document why they didn't do it.

"If you are doing only retrospective data collection, you've missed an opportunity to intervene and improve patient care," she says.

Hospitals should enlist a physician champion who will help them proactively assess their clinical practices. They should verify data collection and accuracy.

"Many times, data collection is not accurate, which sets the hospital up for failure," she says.

The hospital should assemble the appropriate teams to address the issue and make every clinical person aware of what is going on.

People involved should include physicians, nurses, ancillary services, case managers, and health information management.

In the late 1990s, Fugate worked with a hospital system to develop performance improvement initiatives for patients with pneumonia and congestive heart failure.

The team developed physician-driven protocols and used them to develop multidisciplinary pathways that included the most important pieces of information and processes to ensure that patients got the proper care in a timely and efficient manner.

"We worked on standardizing processes and creating care coordination across the organization, not just involving case managers, but a broader look to improve quality of care with the case manager overseeing the process," Fugate says.

She trained the staff to work with other disciplines that are part of the process and to build relationships. "We break down the silo effect, the attitude that 'It's not my job,'" she says.

The pathways included specific patient education for each diagnosis and identified the top goals for that patient. For instance, goals for congestive heart failure patients included smoking cessation; monitoring signs and symptoms of illness, such as weight gain; and reducing sodium intake. The goals were either on the patient chart or posted in the room. Everyone on the staff who went into the room was responsible for discussing the goals with the patients.

"Patients remember only 10% to 20% of what you tell them. If you tell them one time, they're not going to remember it. You have to go over and over it," Fugate notes.

Case managers should conduct daily oversight of individual patient plans of care and work with the physicians to ensure the recommended guidelines are met.

For instance, a recent survey by the American Health Quality Association showed that 31% of patients considered ideal candidates for ACE inhibitors were discharged without a prescription. This is a prime example of an area where case management intervention can improve outcomes, she adds. ■

Hospitals improve CMS project performance

Case managers lead the multidisciplinary team

An enhanced care management program is the keystone of Bon Secours Health System's systemwide performance improvement initiatives in connection with the Centers for Medicare & Medicaid Services' pay-for-performance demonstration project.

The 24 hospitals in the Marriotsville, MD-based Bon Secours system are among 278 Premier Inc. member hospitals nationwide that are participating in the project.

The case managers at Bon Secours do concurrent review, tracking standing order sets, and identifying patients who should be receiving the recommended indicators that are part of the project, says **William Varani**, MD, vice president for quality improvement.

"The case management interventions give us the ability to recognize a patient and a protocol and the compliance with the protocol in real time," he adds. In addition to nurse case managers, the quality improvement team includes a clinical champion, a performance improvement expert, and representatives from other disciplines such as pharmacy and respiratory therapy when appropriate, Varani explains.

"We have spent many years arguing that appropriate incentives for quality would result in quality improvements, health care efficiency, and better outcomes for patients. That is what we are setting out to demonstrate in this demonstration project," he adds.

The hospital system's performance improvement project includes performance improvement experts and staff who are trained in Six Sigma methodology. **(For more information on how hospitals are using Six Sigma to improve care,**

see *Hospital Case Management*, June 2004, p. 85.)

The hospitals examine their own performance and identify areas where improvement is needed. They submit monthly progress reports on the demonstration project's key measures, including barriers to meeting the goals and plans for improving compliance.

The data go to a web site that is shared by all Bon Secours participants in the project. The hospitals in the Bon Secours system submit monthly progress reports on the demonstration project key measures, including barriers to meeting the goals and their plans for improving the process.

Eventually, the data will allow Bon Secours to identify the best practices and recommend them to all the hospitals in the health system, Varani says.

Bon Secours Health System created a system-wide approach to track clinical effectiveness, length of stay, cost per case, and mortality rate for its 24 acute care hospitals several years ago, he says. "Everybody reports on some variation of similar things, but we couldn't draw very many conclusions because everybody's processes and definitions were different and nobody tracked the exact measures."

The Medicare measures and definitions made it easy to standardize processes and to focus on across-the-board improvement, he adds.

Here are some projects that other hospitals in the pay-for-performance demonstration project are trying:

- **Eliminating the silos and barriers to communication between departments.**

The executive team must be on board to support the process and see that it happens, says **Jan McNeilly**, RN, CPHQ, CHE, principal for clinical advisor services at Premier Inc.

"If you are talking about discontinuing an antibiotic at 24 hours for hip and knee replacement patients, the pharmacy as well as the surgeon has to be involved," she says.

For instance, if the patient has the first dose before the incision and every eight hours after that, a two-hour delay in the medication could delay meeting the goal of discontinuing it in 24 hours. The pharmacy must be involved to help modify the process to make sure the patient gets the last dose within the 24-hour window.

- **Developing multidisciplinary teams for each targeted populations to make sure no one slips through the cracks.**

"Multidisciplinary teams can hit these issues very successfully," McNeilly notes.

Clinical Conditions, Measures for Reporting, and Incentives

Acute myocardial infarction
1. Aspirin at arrival
2. Aspirin prescribed at discharge
3. ACE inhibitor for left ventricular systolic disorder (LVSD)
4. Smoking cessation advice/counseling
5. Beta-blocker prescribed at discharge
6. Beta-blocker at arrival
7. Thrombolytic received within 30 minutes of hospital arrival
8. PCI received within 120 minutes of hospital arrival
9. Inpatient mortality rate

Coronary artery bypass graft (CABG)
1. Aspirin prescribed at discharge
2. CABG using internal mammary artery
3. Prophylactic antibiotic received within one hour prior to surgical incision
4. Prophylactic antibiotic selection for surgical patients
5. Prophylactic antibiotics discontinued within 24 hours after surgery end time
6. Inpatient mortality rate
7. Postoperative hemorrhage or hematoma
8. Post-op physiologic and metabolic derangement

Heart failure
1. Left ventricular function assessment
2. Detailed discharge instructions
3. ACE inhibitor for LVSD
4. Smoking cessation advice/counseling

Community-acquired pneumonia
1. Percentage of patients who received oxygenation assessment within 24 hours prior to or after hospital arrival
2. Initial antibiotic consistent with current recommendations
3. Blood culture collected prior to first antibiotic administration
4. Influenza screening/vaccination
5. Pneumococcal screening/vaccination
6. Antibiotic timing, percentage of pneumonia patients who received first dose of antibiotics within four hours after hospital arrival
7. Smoking cessation advice/counseling

Hip and knee replacement
1. Prophylactic antibiotic received within one hour prior to surgical incision
2. Prophylactic antibiotic selection for surgical patients
3. Prophylactic antibiotics discontinued within 24 hours after surgery end time
4. Post-op hemorrhage or hematoma
5. Post-op physiologic, metabolic derangement
6. Readmissions 30 days post-discharge

Source: Centers for Medicare & Medicaid, Baltimore.

For instance, most hospitals have low scores on the smoking cessation indicators during the initial scoring because, even though they have smoking cessation programs in place, they don't have a standardized way to identify who qualifies for the program and ensure these people get involved.

In these cases, the nursing and respiratory care teams collaborate to make sure the documentation is in the chart identifying the smokers and including details on what the team has done.

- **Conducting concurrent rounds to ensure the patients are receiving recommended care**.

In most cases, a nurse or case manager does the rounds. One large hospital has hired a couple of physicians to make rounds in the morning and look at targeted cases, regardless of who the admitting physician is.

For instance, if the patient has congestive heart failure and a recommended drug isn't ordered, the physician will call the admitting physician, describe the recommended care, and find out if he or she has a reason for not prescribing it. In some cases, the drug may be contraindicated for particular patients. In that case, the hospital should have a note in the chart to explain it.

"They are trying to catch the patient in the hospital and fix it then, rather than gathering retrospective data, which is like shutting the barn door after the horse is out," McNeilly says.

As part of the concurrent rounding, hospital staff check to ensure any condition the patient has is documented. Some have a system in place that sends a flag whenever it may be one of the targeted diseases. For instance, any time an order for lasix is sent to the pharmacy, it raises a flag to trigger the case manager to look at the chart to see if the patient belongs in one of the targeted populations.

In some cases, a patient might be admitted with a diagnosis of shortness of breath that is changed to congestive heart failure as the hospitalization progresses.

"By picking up on the lasix order, the staff can see the potential for congestive heart failure while the patient is in the hospital instead of doing retrospective review and determining the patient didn't get the recommended ACE inhibitor when it's too late to do anything about it," she adds.

- **Creating detailed discharge instructions**.

Instead of generic discharge instructions, many hospitals are tailoring them for a specific population. For instance, congestive heart failure patients receive specific discharge instructions, including information about weighing themselves daily.

The hospitals give these patients logs to record their weight and medications each day, and in some cases, a case manager calls patients after discharge to ask them about their weight and medication.

- **Ensuring standard orders are followed.**

Most hospitals already had standing orders or are working on them to guide physicians and prompt them to provide the recommended care. Case managers are reviewing the patient files and working with the physicians to document the exclusion criteria if the recommended care was not provided.

"We're trying to get the physicians to realize that if we are not providing evidence-based care, we need to explain why," McNeilly notes.

- **Making individual departments accountable**.

The hospitals are determining who is responsible for a certain metric and making them accountable if it is or isn't done.

For instance, in many hospitals, 80% of the patients come through the emergency department (ED). In that case, ED staff are responsible for starting the antibiotics in the case of pneumonia patients. At the same time, the pharmacy is responsible for sending the drug to the ED in a timely manner.

"We're looking at the whole accountability issue. Sometimes, we hold people accountable, but we don't give them data to say how they're doing," she says.

Many hospitals are providing data to the department that should be involved in each process, showing how they are doing on meeting the quality measures. ■

Telephonic program cuts CHF readmissions in half

Nurses follow up after discharge

A post-discharge follow-up program for congestive heart failure (CHF) patients has decreased the readmission rate by more than half at Harper University Hospital in Detroit.

Nurse case managers specially trained to do triage assessment by telephone follow up with the CHF patients after discharge, making sure

(Continued on page 143)

CRITICAL PATH NETWORK™

Compliance with protocols may improve outcomes

First large-scale safety study of CABG procedures

What has been called the first large-scale study to examine patient safety issues for isolated coronary artery bypass graft (CABG) showed that hospitals with the highest compliance with three recommended protocols had notably lower risk-adjusted mortality rates than those hospitals whose compliance ranked in the bottom 20%.

Representatives of Premier Healthcare Informatics in San Diego and Aurora Health Care in Milwaukee presented the results of the study, "Metrics and Measurement in Patient Safety," at the Sixth Annual National Patient Safety Foundation (NPSF) Congress in Boston on May 5.

The yearlong study, which included 134 hospitals and more than 40,000 patients, examined the effectiveness of care using widely accepted protocols (i.e., use of aspirin, beta-blockers, and an internal mammary grafting procedure) and the impact on patient safety and costs.

The findings showed that the variance between the top- and bottom-quintile (i.e., 20% increments) hospitals in terms of compliance with these protocols was as high as 22%. For example, the top quintile used beta-blockers 97.9% of the time, compared to 75.1% for the bottom quintile.

The top quintile also had a risk-adjusted mortality rate of 2.4%, compared to 2.8% for the bottom quintile, a 14% difference. Given that some 350,000 CABG procedures are performed annually in the United States with a mortality rate of 2.66%, according to a *Journal of the American Medical Association* study published January 2004, a 14% improvement in mortality outcomes would translate into 1,300 saved lives a year.

In addition, approximately 4% of all CABG patients were flagged with one or more patient safety indicators (PSIs), which indicate that the patient is at risk for a preventable adverse event. The excess variable cost per case for PSI patients was $15,620.

No correlation was found between hospital volume of CABG procedures and observed PSIs, although hospitals that did fewer than 200 procedures had much wider variances in performance.

The NPSF study was developed using data from Premier's Perspective, a web-based clinical performance measurement system that provides patient-level detail to identify opportunities in clinical quality and efficiency.

"PSIs have been studied before — someone did not just grab these out of the clouds — but the validity and true applicability to measure and monitor patient safety outcomes indicators has not been definitively validated, and that's what we were trying to do," says **Kathryn Leonhardt**, MD, MPH, associate medical director for care management at Aurora Health Care.

"Our biggest challenge in patient safety is building a repository of solid evidence that validates how patient safety indicators and interventions directly impact clinical outcomes," she adds.

"This study is important because it examines patient safety across a broad range of hospitals. While its results are not conclusive, they do support the protocols recommended by the Agency for Healthcare Research and Quality [AHRQ], JCAHO [Joint Commission on Accreditation of Healthcare Organizations], and others. In addition, the study suggests that effective care is not only safer but also more cost-effective, which is consistent with the limited literature available on this topic."

Aurora and Premier have been working together since 1995, says Leonhardt, with Premier providing informatics services to process its data for process

and quality improvement. "As the movement to focus on patient safety grew, my role became that of orchestrating and facilitating those efforts all within the system," she says. Aurora Health Care is a not-for-profit provider with 14 hospitals and 120 clinics to serve 80 communities throughout eastern Wisconsin.

Premier, she notes, recently developed a program through which they utilize AHRQ's 20 patient safety indicators.

"As this conference approached, I started talking with Premier about their sizable database, and if, from our perspective as a local care provider, we could use it to drive patient safety efforts. CABG is a high-volume, high-risk, high-visibility quality issue, involving many regularity requirements on outcomes and processes of care," Leonhardt explains.

She asked Premier to draw the required information from data it had already collected for its database and determine how useful it would be.

"These PSIs are fairly new and have not necessarily been utilized across the board as measurements of safety," Leonhardt notes.

The results of the study indicate that the PSIs do have validity and applicability, she points out. "It's not definitive, however. For that you need multiple studies. It was impressive on the large scale, but much harder on the small scale — the individual hospital level."

Leonhardt explains that when you drill down in the data from, for example, 40,000 cases to 1,000 cases, "you lose some of the forest for the trees." She recommends using the larger numbers as benchmarks, norms, and target goals.

"In other words, if for all 40,000 total, the norm is X% and the top performers were X - 10%, how do we compare?" she asks.

Leonhardt adds that the data all are APC/DRG-adjusted, "So we should be dealing with apples and apples."

In summary, the study showed these reports give a snapshot of some of the safety indicators that are measured, Leonhardt says.

She cautions, however, that it "should not be a definitive statement of hospital safety outcomes, but rather to give you overall clinical conditions around those safety indicators." ■

Clinical guidelines for palliative care published

Initiative recognizes growth, maturity of field

The National Consensus Project for Quality Palliative Care, a consortium of five palliative care organizations, has released a set of clinical practice guidelines to promote quality palliative care in the United States.

The "Clinical Practice Guidelines for Quality Palliative Care" seek to support quality and reduce variation in new and existing programs, develop and encourage continuity of care across settings, and facilitate collaborative partnerships among palliative care programs, community hospices, and a wide range of other health care delivery settings.

The consortium members are the American Academy of Hospice and Palliative Medicine in Glenview, IL; Center to Advance Palliative Care, Mount Sinai School of Medicine in New York City; Hospice and Palliative Nurses Association in Pittsburgh; Last Acts Partnership in Washington, DC; and the National Hospice and Palliative Care Organization in Alexandria, VA.

"The field of palliative care has grown rapidly," observes **Diane E. Meier**, MD, FACP, director of the Center to Advance Palliative Care and a member of the project steering committee.

"But depending on where you were, there was a great variability in the definition of 'palliative care.' It could mean one nursing home program that basically consisted of liberalized visiting hours, or an interdisciplinary team with a certain skill set." As the field grew, she continues, the need for benchmarks — a gold standard to work toward — eventually became obvious.

"It's so early in the life of the field that we don't want mandated standards, but we should be planning for a general interdisciplinary team, 24-7 coverage, training, and so on," Meier explains. "These guidelines have been created to try to assure a high level of quality for a growing number of palliative care programs across the country, some level of consistency among and between them, and a set of benchmarks against which programs can compare themselves."

The project's initial leadership meeting took place in December 2001. Involved in discussions were the five leading palliative care organizations and several hundred leaders in a range of disciplines and health care settings who served as advisors.

"This really does reflect the consensus of a broad group of leaders," Meier asserts. First,

existing guidelines from Canada, Australia, and Great Britain were reviewed. "A number of other nations had previously developed guidelines," she explains. Similarities and differences of funding and structure were examined.

An evidence-based literature review also was conducted. "For some issues, there are clearly evidence-based random control trials, like the assessment of pain; for others, like the benefit of bereavement support, there were not," Meier observes.

The steering committee (four representatives from each of the five consortium members) developed a writing subcommittee, which developed a detailed outline that was reviewed and edited. "Then it wrote the actual document, which went through a number of iterations and review by the steering committee and external reviewers," she says. The final product identified these core elements of palliative care:

- patient population;
- patient- and family-centered care;
- timing of palliative care;
- comprehensive care;
- interdisciplinary team;
- attention to relief of suffering;
- communication skills;
- skill in care for the dying and bereaved;
- continuity of care across settings;
- equitable access;
- quality improvement.

In outlining the guidelines, quality palliative care was addressed in eight distinct domains:

1. structure and process of care;
2. physical aspects of care;
3. psychological and psychiatric aspects of care;
4. social aspects of care;
5. spiritual, religious, and existential aspects of care;
6. cultural aspects of care;
7. care of the imminently dying patient;
8. ethical and legal aspects of care.

A number of elements of the guidelines strike Meier as either new or especially significant in terms of general palliative care. "I'd say the first thing is the requirement for an interdisciplinary team. That's not to say that every hospital should have a full-time nurse, doctor, and social worker, but rather that there should be expertise from those fields available. This is a requirement. I know there are a lot of programs that are only a single physician or nurse practitioner; those programs will now need to look at how to create interdisciplinary resources." she notes.

Another unique element is the provision of bereavement support. "This is not routinely offered in U.S. hospitals, yet we know that over 50% of us die in hospitals, not hospice, so some form of screening and support has to be built in," Meier adds.

Other elements of the guidelines are not unique to palliative care but may not be sufficiently widely recognized or utilized in the field. "They include error reduction and use of routine QI methods, and what goes with that is the requirement to measure — that, too, will be novel," she says. "You can't be confident you are delivering high-quality care unless you measure."

Meier adds that it's too early in the life of this specialty to push for required compliance. "People feel they don't need any more regulatory stranglehholds right now. We've established these guidelines not as a requirement, but as a gold standard. My hope is that over the next decade, these will become not the exception but the rule."

At present, American Hospital Association membership surveys show 25% of respondents have palliative care programs, she says. "When we get to the point where it's two-thirds or three-quarters, that will be the point where it's likely the Joint Commission [on Accreditation of Healthcare Organizations] and other accrediting bodies will include guidelines for palliative care as a condition of accreditation." Nevertheless, Meier adds, "This is a huge step forward for the field. When you have consensus guidelines, it's a statement of maturity."

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For the new palliative care guidelines, go to www.nhpco.org under "What's New."] ■

Do you keep stroke patients waiting too long?

She may be an ideal candidate for thrombolytic therapy: A woman tells triage nurses that she first noticed symptoms exactly two hours ago. But by the time the patient is appropriately assessed, the window of time for eligibility to be treated with thrombolytics has passed.

Has that occurred in your emergency department (ED) recently? Currently, only 2% to 5% of all eligible patients receive the thrombolytic drug

t-PA (tissue plasminogen activator), which was approved in 1996 for treatment of ischemic stroke within three hours of symptom onset.[1]

Although there is widespread support for the use of thrombolytics in stroke, not everyone is convinced by the existing evidence, explains **Heidi Jahnke**, RN, MSN, clinical research nurse at Barrow Neurological Institute of St. Joseph's Hospital and Medical Center in Phoenix. "Some argue that this treatment should not be used until far better evidence of its benefits outweighs its harm," she says.[2]

Now a new study shows that acute ischemic stroke patients treated within 90 minutes with t-PA have the best chance of recovery. Results showed that t-PA may be of some benefit to patients up to four hours after symptom onset, but those treated in a five- or six-hour window had almost no benefits.[1]

New drugs may exceed the current three-hour window, with several current clinical trials using thrombolytic agents in acute ischemic stroke for up to 24 hours, Jahnke predicts. "We'll have to await the data analysis to see if the benefits outweigh the risks, but it would be great to have another agent to use beyond three hours." (To review clinical trials for stroke, go to www.clinicaltrials.gov. Type in "stroke" in the "Search Clinical Trials" box.)

If a new thrombolytic was available for use within a four- to five-hour window of symptom onset, it would significantly increase the number of patients who could be treated at the ED, says Jahnke. "For instance, all of our 27 stroke patients in March 2004 were seen within six hours of their symptom onset," she says. "These patients potentially would have been considered for treatment if a new drug was available."

To increase the numbers of stroke patients eligible for treatment, do the following:

• **Educate nurses about stroke signs and symptoms.** "In our ED, we undertook a huge education program on signs and symptoms for what resembles a stroke, including headache, facial numbness, and one-sided weakness," says **Tom Garrity**, RN, an ED nurse at St. Joseph's.

All ED nurses were inserviced by the stroke neurologist and clinical educator on presentation of stroke. "These signs and symptoms are also printed on the back page of our acute stroke pathway," he says. As nurses became aware of the full range of symptoms patients could present with, the stroke team then focused on the importance of quickly identifying patients who needed immediate assessment: those who presented within a three-hour window with ongoing symptoms, Garrity says.

Public information campaigns about the warning signs of stroke, coupled with education of paramedics, has increased the number of patients coming to the ED within the three-hour time window, Jahnke reports.

• **When in doubt, page the stroke team.** "When patients present with vague neurological symptoms, we ask nurses to go ahead and start the pathway and page the stroke team. The neurologist and ED physicians will further evaluate the patient," Garrity says.

• **Get the computed tomography (CT) scan and blood work done immediately.** Standing orders are used for patients placed on the stroke pathway, with the average door to CT scan running about 22 minutes, he adds. "Decision-making time of our neurologists on whether to give t-PA has been a source of delay in our institution, but we are trying to improve on this. ED nurses take t-PA with us now to CT, so that the physician can order the t-PA while the patient is still in the CT area."

• **Identify patients eligible for t-PA.** Patients with stroke symptoms now are designated as "Stroke 1" with symptom onset of fewer than six hours, and "Stroke 2," which are patients outside of that window, Jahnke says. She estimates that the ED sees 20-25 Stroke 1 patients per month and 15-20 Stroke 2 patients. "We treat all Stroke 1-eligible patients with t-PA, unless they decline, which are very few. We treat approximately three to nine stroke patients with thrombolytics per month, or approximately 25% to 35% of the Stroke 1s."

• **Use pre-printed orders.** The ED uses pre-printed orders and protocols, along with a universal pager for radiology technicians and neurology physicians, Garrity explains. The following are expected time frames:

— The neurology resident in the ED assesses the patient within 10 minutes.

— Labs and CT are done within an hour of the patient's arrival.

• **Share success stories with staff.** "This helps reinforce to our ED staff how important this early recognition is to our patients," Garrity says.

References

1. The ATLANTIS, ECASS, and NINDS r-t-PA Study Group Investigators. Association of outcome with early stroke treatment: Pooled analysis of ATLANTIS, ECASS, and NINDS rt-PA stroke trials. *Lancet* 2004; 363:768-774.

2. Hoffman JR. Tissue plasminogen activator (tPA) for acute ischemic stroke: Why so much has been made of so little. *Med J Aust* 2003; 179:333-334. ■

Three strategies to reduce overcrowding and gridlock

Want to cut your diversion hours down to zero? That's exactly what Hoag Memorial Hospital Presbyterian in Newport Beach, CA, has done by instituting its emergency saturation triage, or Code EST. When Code EST was implemented in July 2000, diversion hours were about 130 monthly.

There are multiple reasons to reduce diversion hours. Missed service and revenue opportunities are two, says **Marty Karpiel**, FACHE, FHFMA, president of Karpiel Consulting Group in Long Beach, CA.

And always keep in mind why you're there, says **Ray Ricci**, MD, FACEP, an emergency department (ED) physician at Hoag Memorial. "To deny patients access to care is contrary to the hospital's mission," he says.

Here's how the successful Code EST process works: "Once the ED approaches saturation, and while we are holding patients who need to be admitted, we want to let everyone in the hospital know how bad it's getting in the ED," Ricci notes. "The idea is that all the people who have influence on moving patients out of the hospital will take extraordinary measures to prevent closure."

When Code EST is announced over the loudspeaker, a chain reaction is set in motion.

"The charge nurse contacts the nursing supervisor; the nurse super comes down to assess needs as to who needs be put upstairs," he says. "The lab is asked to send over a phlebotomist if one is needed. Radiology is asked to have all ED patients expedited."

The process goes beyond medical staff. The head of housekeeping must prioritize bed cleaning for any beds not clean at the moment. She is given a list of the type of beds needed most urgently, and the housekeeping staff then scours the hospital for unclean beds. Transportation staff come to the ED and transport anyone who can go into the next open room. Pharmacy support also is available — i.e., an acute pneumonia patient may be given meds in the ED.

Hoag's ED staff are hoping to add a new requirement to Code EST: that charge nurses from the floor actually come to the ED to share their information.

Even more important than the 15-20 minute meeting in the ED to discuss the situation on their floor is that "they get to share the pain a little bit. They tour through the waiting room, see kids with fevers, vomiting in buckets," Ricci shares. "I hope this will give them some compassion for people waiting for that bed upstairs."

A very simple, but effective strategy involves pre-emptive bed requests, Karpiel says.

"The process of getting a bed in a hospital may take five or more phone calls and from one to four hours or more," he observes. "If we are able to identify the need for a bed sooner and start the admitting process sooner, we might be able to cut that time."

The basic premise is this: Any good emergency physician or nurse can walk in a room, look at the patient, and almost immediately determine with a high degree of reliability whether the patient needs to be admitted and what kind of bed the patient would need. "So why not start the process then and there, rather than waiting to admit the patient and then begin waiting for a bed?" poses Karpiel.

Adventist Medical Center in Portland, OR, has been using pre-emptive bed requests for about two years and has cut turnaround time from 3.5 to four hours down to two to three hours, says **Jan Paquette**, MD, FACEP, ED director. However, pre-emptive bed requests must be part of a larger multidisciplinary program to decrease your turnaround, she adds.

The disciplines that need to be at the table are those affected by patient admission, she maintains. "The planning meeting should include representatives of the emergency physician, nursing

and unit secretary staff, the admitting clerk, the nursing supervisor, and housekeeping," Paquette says.

All of these discipline must be at the table to be educated to respond to this change in process, she explains. It's typical for admission clerks to submit the patient's name, diagnosis, and attending at time of bed assignment, she says.

"But with pre-emptive beds, you have to change the process so they take the name, plus general diagnosis class — i.e., chest pain — without a doc assigned," Paquette says. "At that point, housekeeping can be notified, the bed can be made, and the nursing staff can be prepared to receive the patient. All of these processes can start earlier."

Another win-win strategy involves creative staffing. Ricci says the initial plan was to try to have space where admitted patients could go before they went on the floor.

"But after vainly looking for unused space, we flipped our thinking," he says. "Instead of having a space where patients could go to see new nurses in preparation for going upstairs, why not add a nurse to the ED staff and have him or her be the emergency care admit nurse?"

This doesn't gain you any space, he concedes, but it transfers the responsibility of the laborious process of admitting paperwork from the ED nurse to this new nurse.

"The ED nurses are delighted, the nurse on the floor is much less resistant to that new admission, because he or she knows the 17 pages of paperwork already are done," Ricci says.

Speaking of win-win, all of these strategies result in a win for the ED and for the hospital. "If you can improve throughput time on access to beds, or reduce patient stay by half a day in a 300-bed hospital, it's the equivalent of adding 30 more beds to that hospital," Karpiel asserts. ■

How ED managers can find those elusive beds

One of the issues constantly plaguing emergency departments (EDs) is the hidden bed — a precious commodity when a crunch is on. But there are a number of methods that can help identify those beds sooner, says **Marty Karpiel**, FACHE, FHFMA, president of Karpiel Consulting Group in Long Beach, CA.

"There are several bed tracking systems available," says Karpiel, adding that the BedTracking software from Pittsburgh-based TeleTracking Technologies is the only one he has seen in action.

"They are designed to clearly identify those beds. This way, you take the nurse who may have an incentive to hide the bed out of the loop."

The systems work like this: As soon as staff arrive in the rooms to transport the patients, they key the vacancy into the phone system, which accesses the bed tracking system. This pages housekeeping, so someone is sent to clean the bed.

"When the housekeepers arrive, they punch in that they are on-site," Karpiel says. "Then, when the room is clean, they punch that as well."

In addition to identifying available beds sooner, these systems can help monitor the housekeeping team's efficiency and performance. "This way, the staff have an incentive to get that bed clean, because it shows up in the reports," he adds.

Some hospitals have placed their bed control computers in the ED, so when there is an ED admission, they know what kind of bed they need.

"The charge nurse in the ED can access the control system if they have a terminal, identify a bed, and immediately contact that floor charge nurse," says Karpiel.

The system costs about $50,000, including hardware and software plus training, says **Ray Ricci**, MD, FACEP, an ED physician at Hoag Memorial Hospital Presbyterian in Newport Beach, CA. (An additional annual licensing fee is based on the number of beds.) "When you look at the cost and benefit, it's very small," he says.

The challenge for any bed tracking system, he adds, is the old GIGO (Garbage in; garbage out) adage. "The issue is who puts the data in. You can't have the nurse on the floor do it. It's like having the fox guard the hen house." The Code EST (emergency saturation triage) at Hoag Memorial also helps uncover hidden beds, says Ricci.

"[When the code is called], the housing supervisor contacts admitting and finds out what beds they have listed as open, then matches them with what the charge nurses on floor report," he says. "When admitting says there are no more beds, and we're about to go on diversion, we call a Code EST, and lo and behold, the housing supervisor finds four beds. Somehow, beds become available." ■

EDs struggle with growing numbers of uninsured

'Expect problem to get worse — plan accordingly'

In addition to increased numbers of mentally ill patients, emergency departments (EDs) are seeing more uninsured patients than in the past, and the numbers could grow, warns **Brian Hancock**, MD, president of the American College of Emergency Physicians (ACEP) in Irving, TX. Your budget planning should factor in more uninsured patients, not just the same level you have coped with for years.

Hancock has seen the increase in his own ED. "I've been an emergency physician for more than 20 years, and each year, I see an increasing number of uninsured patients," he says.

And the evidence is more than anecdotal. According to Hancock, ACEP research indicates 72% of physicians report the number of uninsured patients they treated in the past year increased, and 79% say the figure likely will increase again during the coming year.

ED physicians also indicate that the uninsured patients they treat are more likely to delay care, suffer from illness, and put their physical and financial health in jeopardy than are patients who have health coverage, Hancock says.

Too often, the ED care only is a stopgap measure that fails to address the underlying health problems, and the patients soon return to the ED, he adds. "While we treat and stabilize them in the emergency department, after they are released, many are faced with the decision of whether to spend their money to fill a prescription, follow a recommendation to see a specialist for follow-up care, or buy groceries that week. This is a trend that ED managers have to consider when planning for the future. Unless things change dramatically, EDs will continue to face a real burden."

The emergency physicians who were surveyed rated securing specialist referrals, ensuring routine follow-up care, and filling prescriptions as the three most challenging tasks to coordinate for uninsured patients.

Contribute to overcrowding

Eighty-two percent of the physicians surveyed said their hospital's ED functions at or over capacity on a typical weekday, and the share increases to 91% for a typical weekend.

Uninsured patients seeking nonemergency care contribute significantly to that overcrowding, Hancock says.

"This is a problem that poses practical challenges to EDs in terms of management, and planning is key," he says. "The long-range solution will be improving the health care system so that our patients don't have to choose between proper health care and other necessities. In the meantime, you have to expect the problem to get worse, and plan accordingly." ■

Reader Question

If nurses hoard patients, can you improve flow?

Question: How do we avoid patient "hoarding," in which nurses or physicians intentionally delay moving a patient out to delay the next patient and give themselves a breather? We've already warned that hoarding won't be tolerated, but it still happens and thwarts our efforts to improve patient flow through and decrease waiting time.

Answer: Hoarding patients is an age-old technique for slowing down the workload, and chances are good that all emergency departments (EDs) have been the victims at one time or another, says **Marilyn Margolis**, RN, MN, director of nursing for emergency services with Emory Hospitals in Atlanta.

But ED managers must work proactively and aggressively to stamp out this practice, because it can undermine all your other hard work, she says.

Hoarding is very different from "boarding" patients until a bed is available elsewhere in the hospital. Hoarding is voluntary and done on the sly. It can be hard to detect because the nurse or physician doesn't have to do anything overt; simply failing to discharge or transfer a patient as soon as possible can be enough to slow down the process.

"EDs are so overcrowded, and we're working our nurses and physicians so hard, that it's almost understandable when they want to take a little bit of a breather, because it's just constant

chaos," Margolis points out.

"But even if we understand why they're doing it, we can't let that be the solution because it creates bigger problems," she notes.

The solution is to create incentives for nurses to move their patients, she says. In her ED, the admission policy calls for rotating new patients through each nurse's zone rather than simply going to the first available bed.

That helps avoid having nurses feel they are penalized for being efficient and clearing beds fast, adds Margolis.

"If you move four patients out quickly, we're not going to necessarily send you four patients right away to fill those beds, " she explains. "They will go to the zone that is next in the rotation instead of dumping all of them on you."

That strategy has to be flexible so patients don't back up and empty beds go unused because they're in the wrong zone; but Margolis says the idea helps reassure nurses that they can move patients out without another appearing instantly.

Using techs in expanded roles

Emory also has increased the use of nurse technicians and expanded the typical tech's role to include starting intravenous lines, transporting patients, and drawing blood samples. She points out that some EDs employ paramedics for these expanded tech roles.

The ideal arrangement would be a tech devoted to each nursing zone, but Emory doesn't have quite that many. Nurses benefit from the assistance of the techs, which in turn decreases any temptation to hoard patients, she says.

Emory also is about to introduce a new tracking system for the ED, moving patient flow to the bedside. The triage nurse will handle placement of the patients, allowing the charge nurse to concentrate on patient flow and assist with patient care.

Another idea in the works at Emory is a "discharge expediter." This nurse would take care of discharging patients rather than having the zone nurse be responsible for discharging his or her own patients.

All of those strategies can help take the pressure off of nurses so they are not inclined to subvert patient flow through, but hoarding still can happen. When you detect hoarding, Margolis says you must act. But reprimanding the individual nurse or physician isn't enough.

"When we see people trying to purposely slow down the flow, we address it in a system way," she continues. "If people are so overworked that they're trying to slow down the system, we need to see why they want to do that and how your systems can improve. Staff appreciate that philosophy and see that we're not being punitive, that we want to improve the whole system."

So even at Emory, with all its resources and proactive strategies, does hoarding still happen?

"Oh yeah, it happens," Margolis admits. "If we see it with an individual, we address that person directly, but we don't make it punitive. We would be more likely to ask, 'What can we give you to help you expedite patients quicker?' In our experience, that works better than just coming down hard on the person who was slowing things down." ■

CE *questions*

9. The CMS Hospital Quality Incentive Demonstration Project includes quality indicators from which of the following?
   A. Agency for Healthcare Research and Quality patient safety indicators
   B. The Leapfrog Group indicators
   C. CMS 7th Scope of Work indicators
   D. all of the above
10. According to Teresa Fugate, RN, BBA, CPHQ, CCM, manager at Pershing, Yoakley & Associates in Knoxville, TN, data on quality indicators should be collected retrospectively rather than concurrently.
   A. true
   B. false
11. How often do the 24 hospitals in the Bon Secours Health System submit progress reports on key measures related to the CMS pay-for-performance demonstration project?
   A. weekly
   B. every other week
   C. monthly
   D. annually
12. What condition represents the highest volume admission at Harper University Hospital in Detroit?
   A. asthma
   B. chronic obstructive pulmonary disease
   C. acute myocardial infarction
   D. congestive heart failure

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

(Continued from page 134)

patients monitor their weight and blood pressure on a daily basis and reinforcing the patient education instructions patients received during their hospital stay.

"The results have been quite dramatic and quite beneficial for the patients," says **Joseph Bander**, MD, the hospital's vice president for medical affairs. It's one good example of how hospitals can provide good quality care at less expense."

The hospital started its CHF program two years ago.

The patients are enrolled in the program while they are in the hospital. After discharge, three nurses dedicated to the program call the patients twice a week for the first month and follow up at less frequent intervals for as long as six months, educating the patients for signs and symptoms to watch for in the course of their disease.

Depending on the symptoms, the patients are either managed by the nurses over the telephone or urged to see their physician.

"If patients can be identified if they are getting in trouble much earlier in the course of the disease, they don't need as much intervention. Their quality of life is better, the expense of care is diminished, the burden on the third-party payer is diminished, and the patients get better care," Bander adds.

In addition, the telephone calls give some of the patients some social contact that they might not otherwise have had, he adds. "They are aware that we care about them."

The hospital created a separate staff, rather than use the hands-on nursing staff, to make the telephone calls. "For us, it makes sense in terms of better care, and since readmissions are not reimbursed by Medicare within a certain time frame, it makes financial sense to dedicate staff to work with the patients to prevent costly readmissions," Bender explains. The hospital is developing similar programs for diabetes, hypertension, and other diagnoses, he adds.

CHF is Harper University Hospital's highest volume admission and one that has a high mortality rate for patients over time, Bander points out.

"Once a patient starts to develop congestive heart failure, there is a marked increase in mortality, and perhaps their lives are shortened unnecessarily. The program has given us better financial outcomes and better quality of care for the patients. It's a win-win situation," he says.

CHF is a diagnosis for which there are frequent readmissions, Bander notes. "It's a diagnosis that requires a lot of patient education and follow-up on a regular basis. A busy physician simply cannot follow up in the way that is needed. That's why we committed our nursing personnel to do so."

The nurses selected to make the outbound calls are highly experienced and undergo a lengthy training process to learn to assess patients over the telephone. "Telephone assessment is very different from bedside assessment. Hands-on nursing requires a different skill set," he says.

The nurses have a checklist of items to cover when they call the patients, including daily weight, blood pressure, and dietary questions.

As patients are enrolled in the program, the hospital provides them with an automatic blood pressure cuff and a scale to make sure they can measure their daily weight and blood pressure.

The hospital has developed very explicit discharge instructions for CHF programs. Patients can call a nursing line 24 hours a day, seven days a week.

The three CHF nurse case managers answer the telephone during their working hours. The line is covered by other staff after hours.

While the patients are in the hospital, specially selected clinical resource management nurses review each chart to make sure the care is consistent and follow the hospital's best practice guidelines for CHF and other targeted diagnoses.

"Our goal is to assure that patients who meet appropriate criteria receive appropriate, nationally

COMING IN FUTURE MONTHS

- Case management's role in JCAHO tracer methodology
- From discharge planning to transition planning
- Legal liability risks every case manager should know
- All new sample clinical pathways for *Critical Path Network*

recognized medical interventions," he says.

As third-party payers are requiring more detailed documentation, physicians face an exceptional load of paperwork and may not include as many details as necessary.

That's where the clinical resource managers come in, Bander explains.

"We have committed ourselves to making sure that nobody falls through the cracks. Sometimes, things can be overlooked, and it helps to have somebody following along to make sure that it's not," he notes.

If the chart doesn't indicate that the patients have received the recommended care, the clinical resource managers get in touch with the physician to find out if there is a reason why and ask them to provide the appropriate documentation.

"It's important for reimbursement and for anyone else who comes along and tries to understand what is going on in the chart," Bander adds. ■

CE objectives

After reading each issue of *Hospital Case Management*, the nurse will be able to:

- 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. ■

Protect your hospital's tax-exempt status

Numerous nonprofit hospitals in multiple states have been hit with class action lawsuits challenging their tax-exempt status as charity institutions, and more are expected to follow. They are charged with allegedly overcharging uninsured patients and subjecting some of them to abusive bill collection practices.

If your nonprofit hospital is typical, it likely is hanging by a financial thread. Do you know what actions you can take to protect its tax-exempt status? And do your staff know about the many alternative services available to help the needy?

Thomson American Health Consultants is offering an audio conference to help you learn where your hospital may be exposed, what policies and procedures you need to reform to preserve your tax-exempt status, and how to continue to provide necessary care for the uninsured.

Billing and Collections Practices Regarding the Uninsured: What You Need to Know to Preserve Your Hospital's Tax-Exempt Status, which will be held Thursday, Sept. 6, 2004, 2:30 to 3:30 pm, EST, will be presented by **Jay Wolfson**, DrPH, JD.

Wolfson is a professor of public health and medicine at the University of South Florida Health Sciences Center in Tampa and is an expert in the field of health care law. He has done extensive research, written numerous books and articles, and given many talks on the subject.

Your facility fee of just $249 entitles you to invite as many participants to listen as you wish. You will receive presentation materials, additional reading, a 48-hour replay of the live conference, and a CD recording of the program upon request at no additional charge. And if you register by Aug. 26th, you will qualify for the discounted facility fee of just $199 (a $50 discount off the regular price of $249). For information, visit us at www.ahcpub.com, or contact customer service at (800) 688-2421 or by e-mail at customerservice@ahcpub.com. When registering, please reference code **T04120-61822.** ■