AMERICAN HEALTH CONSULTANTS®

HOSPITAL CASE MANAGEMENT™

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

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How to contain costs when lengths of stay are low

Even though your hospital may be achieving its targeted lengths of stay (LOS), that doesn't mean revenues are balancing, nor does it mean you are providing high-quality care. 'LOS is a good news/bad news measure,' says Beverly Cunningham, RN, MS, regional director of clinical effectiveness at Mercy Health Partners of Toledo, OH. 'If your LOS is low, pat yourself on the back,' she says. 'But that doesn't mean you have low costs, it doesn't mean your processes are efficient, and it does not mean that you've met the standards of care.' . . . . . Cover

From worst to first: A physician success story

About a year ago, Bimal Jain, MD, pulmonologist with North Shore Medical Center Union Hospital in Lynn, MA, had an average 10.4-day length of stay — one of the worst in his hospital. When a case manager gave Jain the bad news, he vowed to make a change. Today, his LOS is 5.2 days 83

CMSA reaches out to hospital case managers

The Little Rock, AR-based Case Management Society of America (CMSA) has launched a new outreach initiative geared toward hospital-based case managers. CMSA offers acute care and social work special interest groups through membership with the organization. Members of the acute care special interest group have access to an around-the-clock discussion forum, among other benefits. CMSA will also co-sponsor a one-day hospital case management summit later this year 84

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How to contain costs when lengths of stay are low

The first step? Find out where the money's going

Case managers have long known that length of stay (LOS) is, at best, an imperfect measure of a case management department's success. After all, shaving off patient days doesn't mean much if you've simply crammed the same processes and procedures into a shorter time frame — or if you've revised those processes poorly and actually introduced errors or inefficiencies into the system of care.

Although LOS remains on the decline in most parts of the country, recent studies indicate that in the West, with its high managed care penetration, lengths of stay have leveled off and even shown slight increases since 1996, largely because of mandated minimum stays for childbirth. When LOS has been taken as low as it can safely go, some case management experts are asking, what happens next?

"LOS is a good news/bad news measure," says **Beverly Cunningham**, RN MS, regional director of clinical effectiveness at Mercy Health Partners of Toledo, OH. "If your LOS is low, pat yourself on the back. But that doesn't mean you have low costs, it doesn't mean your processes are efficient, and it does not mean that you've met the standards of care."

Cunningham recommends that case managers look beyond LOS to review whether clinically appropriate care was given to the patient without delays and whether physicians accomplished what they meant to. Other areas to consider when LOS is low are readmissions, outcomes, reimbursement, and denials.

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Guest Column

Indicator instrument panels: A key to survival?

Leaders of case management programs often do not communicate on the same wavelength as those who make judgments about program funding and success, according to guest columnist Alan Cudney of Charlotte, NC-based Premiere, Inc. For that reason, it's important to understand the results these stakeholders expect from case management and adopt those results as indicators of success. A template or instrument panel can reveal, at a glance, the level of success the program is achieving. It also can be used to encourage staff to work as a team toward monitoring and reporting indicators targeted for improvement 85

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Providing care for deconditioned frail elders

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COMING IN FUTURE ISSUES

■ Case management staffing: It's the model, not the ratio, that counts

■ A new General Accounting Office study confirms that, across the country, nursing homes are continuing to refuse admission to high-cost patients, driving up hospital lengths of stay

■ Actuarial firm Milliman & Robertson is in hot water again, this time with physicians who claim its standards have little scientific basis

■ How prepackaged discharge kits could make your job easier

■ A new quarterly feature debuts in July: *Discharge Planning Advisor*

The first step in finding out where the money is going when the LOS rate is low is to collect data, which give case managers and physicians evidence that can be used as a model to reduce costs and provide better care.

Deborah Hale, president of Administrative Consultant Services in Shawnee, OK, says data also help you focus. Using pneumonia as an example, a hospital could collect data on the length of time patients are administered IV antibiotics as opposed to the amount of time they are given oral antibiotics. The data should include the frequency and necessity of lab tests, the length of time it takes to get the results back, and whether the tests could have been done on an outpatient basis. Any delays in either receiving completed tests or administering the tests also should be documented, because these are the types of problems that cost money.

Rather than looking at individual cases where variations such as comorbid illnesses can impact results, data should be reviewed in large volumes where case managers can make the most difference, Hale says.

Data are not useful unless they are shared, says Cunningham, who adds that case managers should avoid the mistake of "collecting information and failing to get it back to people who can make a difference."

Cunningham says, "The ultimate goal of case managers is linking people who are out there delivering care to their outcomes. We develop wonderful clinical paths, but the most wonderful part is people who sit down and talk to each other because they are going to link what you talk about to their practice. We will never make a difference in cost until we start taking some of these issues back to the bedside, to the people who make a difference. Even if you think doctors are not working with you and staff nurses aren't working with you, look at LOS two years ago and compare them to now; someone is working with you."

Individual patient information can be given to doctors, nurse managers, case managers, and social workers so they can compare themselves to others, Cunningham says. Hospitals also should compare themselves to hospitals of similar size and location on a quarterly and/or annual basis to determine if their procedures and prices are competitive and cost-effective. Hospitals that lack a compatible facility for comparison should trend themselves from one quarter to the next.

For hospitals that trend, Cunningham suggests looking at high-cost contributors for a given illness. If the LOS goal for pneumonia patients is 4.5 to five days, review the percentage of those who stayed longer than that to determine if anything could have been done to shorten the stay while providing appropriate care.

If there's one illness in particular that is costing the hospital money, Cunningham says that's a red flag for case manager involvement.

Spending money wisely

To conserve money, the best and most effective devices and medicines should be used. "Maybe we are using the most expensive devices because we've always used them, which doesn't necessarily mean they are the best," Cunningham says.

Just because certain procedures have been used over time, that doesn't mean they are the most appropriate for patients. That's where the concept of "evidence-based medicine" comes in.

Physicians have always based their care on research, but evidence-based medicine is proof that certain procedures and practices will result in success, says **Bimal Jain**, MD, pulmonologist at North Shore Medical Center Union Hospital in Lynn, MA. "It provides evidence for what you are doing, and evidence only comes through data — and you can't argue with data," says Jain.

Evidence-based medicine, which standardizes or controls care, also benefits physicians when it validates that the procedures and practices in place are the most cost-effective and beneficial to the patient and the hospital.

Through this type of grounded research, case managers can get a better understanding of why procedures are handled in a certain way, says **Larry Strassner**, RN, MS, manager of health care consulting at Ernst and Young LLP in Philadelphia. When administering blood, the common practice is to take vital signs every half-hour because it is "what we've learned over time." However, research could prove another method is more effective and less expensive.

Case managers also should examine readmissions within 15 days of discharge when the LOS begins to drop, cautions **Aileen Day**, director of medical management at North Shore Medical Center in Lynn, MA. After the patient is released and the insurance company is billed, case managers should be aware of the percentage for which the hospital is reimbursed and the costs of procedures. ■

From worst to first: A physician success story

How one physician bought into case management

About a year ago, **Bimal Jain**, MD, pulmonologist at North Shore Medical Center Union Hospital in Lynn, MA, had an average length of stay (LOS) of 10.4 days — one of the worst in the hospital.

But after a year of working closely with **Aileen Day**, director of medical management at North Shore Medical Center, Salem and Union hospitals, today Jain's LOS is among the best in the hospital at 5.2 days.

Day says she tried something new when she began working with Jain. "I approached Dr. Jain with his data and the data of other doctors, but I didn't accuse him — I just gave him the data," says Day. "His reaction was surprise. At first he thought something was wrong and he asked if I had the right information. He wasn't mad or defensive; he was surprised. I offered to sit down with him, and we began meeting."

Day began giving Jain literature that prompted the discussion of different care options. Eventually, Jain's record improved.

Jain says his interest was piqued when he found out his LOS was among the highest in the hospital. "I decided to take a look and see what I could do," he says.

Meanwhile, Day used the same method with other physicians and was rewarded with similar results. Her record speaks for itself: In one year, the overall LOS at North Shore has dropped by one day and readmissions have not increased. She's helped achieve this success with the support of physicians, case managers, hospital-based managers, and delegated managers at both Salem and Union hospitals. "We no longer work independently. We work together," Day says.

The first problem Jain noticed when he began focusing his efforts on reducing LOS was an issue in his practice. Jain and his three colleagues were switching off rounds, and at any given time the physicians would be caring for five to 12 patients in one hospital. Jain says care decisions were sometimes delayed because of coverage issues.

"I started to [consider whether] patients should stay here or be moved to an extended care facility that specializes in what they need," Jain says. Another option is to send patients home

and allow them to receive further services through outpatient care.

Jain says he started evaluating everything he was doing. "It forces you to find a reason for a patient to be in the hospital. When you have that awareness, it makes you provide better care and examine your patients more closely."

There is a perception that staying in the hospital longer means you will receive better care, Jain says. "From a medical standpoint, the sooner the patient goes home, the better."

Other issues previously unimportant to Jain entered the forefront of his mind, including whether the hospital offers tests on the weekend and whether test results and reports are being returned the same day. Any of these stumbling blocks, along with a host of others, increases LOS and ultimately costs the hospital money.

Jain says he can provide his services in a timely fashion, and his goal is to move his patients though the system efficiently while providing appropriate care.

Jain has resolved most of his LOS problems, but he admits it is a work in progress. His new mission is to help case managers bring other doctors on board. Physicians easily avoid dealing with LOS and case managers by either ignoring them or saying they just don't have the time, he says. "You've got to approach physicians in a different way," he says. "Physicians are besieged on all sides. [A case manager's document] is another document, and it isn't a physician's priority."

The key, Jain says, is understanding that doctors are competitive by nature and letting them solve their own problems. He also says case managers need to approach physicians in a nonthreatening way and try to see things from their point of view, while the case manager acts as the facilitator.

Jain offers himself as an example that such an approach can work. He admits there was a time when he would run and hide when a case manager approached him. "Now, they run and hide when they see me," he says. ■

CMSA reaches out to hospital case managers

Group to sponsor HCM summit this fall

Although the Little Rock, AR-based Case Management Society of American (CMSA) has represented case managers in all practice settings since its founding in 1990, recent survey data suggested that many hospital-based case managers either weren't aware of the organization or didn't know what it could do for them.

To rectify the situation, CMSA has launched an outreach initiative to let hospital case managers know the organization isn't just for case managers in managed care organizations or other practice settings along the continuum of care.

"Even though CMSA had always included and encouraged membership for hospital case managers, it realized that some outreach was indicated because of the difficulty for any case manager of being able to access resources and identify what kinds of support and educational and networking opportunities might be available to them," says **Sandra L. Lowery**, BSN, CRRN, CCM, president of both CMSA and Consultants in Case Management Intervention in Francestown, NH.

Kathleen Moreo, immediate past president of CMSA, says the organization is well aware of the special challenges hospital-based case managers face. "Hospital-based case managers, like the rest of us, are in the midst of a struggle with outcomes," she says. "The main [difference] is that in a hospital, caseloads rapidly change, so, unlike the rest of us, they are not working across a continuum of change. Hospital case managers are different from the others — and that presents its own unique challenge."

CMSA is taking steps to meet that challenge. The society offers acute care and social work special interest groups through a membership with CMSA. Members of the acute care case management special interest group are allowed access to an around-the-clock on-line discussion forum where members can post questions and concerns and confer with colleagues across the country.

At the CMSA annual conference, facilitated special interest group meetings are held. "The national conference will give hospital case managers an opportunity to meet and network face-to-face with providers as well as payers, thus setting the stage for building relationships," says **Anne Llewellyn**, facilitator for the acute care special interest group.

"The special interest group is seen by the health care community as a real resource," Lowery says. "Often, we will get requests for a speaker or to respond to an issue or question. We'll often contact the facilitator of the special interest group, who is also a member, to respond to an industry request that comes through the CMSA office."

Danielle Marshall, director of member/chapter services, says acute care case management "has probably been our fastest-growing membership, so obviously, we're hitting a need."

On Nov. 9, 2000, CMSA will work with the Utilization Management/Case Management Best Practice Conference and Expo to offer an all-day preconference management summit specifically geared to hospital case managers, called Hospital Case Management 2000. The preconference summit will be followed by an acute care track at the second annual UM/CM Best Practice Conference, Nov. 10-11.

The conference will provide an opportunity for hospital case managers to network with other professionals who will be on hand to provide financial, clinical and technological tips on how to go about improving practices, says Llewellyn. Sponsored jointly by CMSA and the Washington, DC-based American Accreditation HealthCare Commission/URAC, the event will be held in San Diego.

Other opportunities for hospital case managers include:

- participation with the leadership of CMSA in several initiatives related to case management professional development and support locally, nationally, and internationally;
- an acute care track at the organization's annual conference in Tampa;
- participation at the local level in CMSA's 70 chapters throughout the United States, many of which offer educational programs geared toward acute care issues;
- fax-on-demand information sheets;
- Information Central, a research service for CMSA members;
- CE programs on-line at CMSA's Web site, free to members.

Future initiatives include:

- development and distribution of a CMSA-sponsored Core Curriculum (summer 2000);
- the second and third scientific papers on case management related to Empowerment and Care Coordination (the first, on Adherence, is already available through CMSA);
- a preconference Case Management Institute, held Nov. 12, 2000, in Baltimore in conjunction with the annual conference of the Disease Management Association of America.

Editor's note: An application for membership to CMSA is enclosed in this issue. For more information about CMSA, call (501) 225-2229 or visit CMSA's Web site: www.cmsa.org. ■

GUEST COLUMN

Indicator instrument panels: A key to survival?

How to communicate with stakeholders

By **Alan Cudney**
Premier, Inc.
Charlotte, NC

A hospital chief executive officer was recently overheard saying, "Let's eliminate some case managers. They don't do anything anyway." Unwittingly, the leader of this troubled hospital was about to make a mistake that could jeopardize the financial viability of his organization. The impact case managers can have has been well-documented, but those who make judgments about program funding and success often misunderstand this impact.

The situation outlined above probably has been repeated in many hospitals across the country. However, it is often avoidable if the case management program director is properly trained and educated. Leaders of case management programs — many of them registered nurses and social workers — often do not communicate on the same wavelength as their physician and health system executive customers. Too many case management leaders expect their administration and physicians to hold the same interests and opinions they do about the importance of their work.

While their training equips them well for their jobs, case management leaders may not understand the business side of health care. The result may be a communication breakdown between case management directors and their stakeholders.

Case management directors can bridge this communication gap by not only identifying their stakeholders but also by working with them to develop a shared vision of desired program results. When asked, "Who is your customer?" most case managers will reply, "the patient and family members." Sometimes a case manager will add, "the physicians." Rarely will a case manager include hospital executives and payers in the list of stakeholders.

To understand all their customers' expectations regarding case management, program

directors must take the first step by familiarizing themselves with current health care business issues, as well as the environments and issues their customers face. Program directors also need to cultivate such an understanding and customer focus among their own staff members.

"I don't care about the money issues; I just want to make sure the patients get what they need," a case management staff member recently stated. While this may seem admirable, hospitals are responsible for performing like businesses. At the same time, they are expected to act as stewards of the resources at their disposal in order to produce positive health outcomes. This dichotomy of purpose in the health care industry should prompt case managers to regard physician and hospital executives as business partners and their own departments as independent case management consulting firms.

The logical next step in developing an understanding of customers' environments, challenges, and expectations is to develop a system for monitoring the case management department's progress in meeting those expectations. Many departments struggle with documenting their achievements because some staff members may not have strong analytical skills. In any case, a small set of indicators (an instrument panel) that reflects stakeholder expectations should be developed and monitored regularly and consistently. Clear, readable reports that track these indicators should be provided to stakeholders.

Create operational definitions

A first step in developing a departmental instrument panel or report is to create an operational definition or description of each indicator. The operational definition should be detailed enough to show which data are needed and where the data must come from. This detail justifies use of the indicator by ruling out the possibility that the data are not available and ensuring that the data are easy to obtain.

Two levels of indicators are needed for proper management of the program. The first level is identified by a high-level summary of program results. This summary is suitable for communicating with key customer groups such as health system executives, physicians, and payers. The second level comprises basic operational indicators such as budget variances and staff absenteeism. This level is useful for monitoring or improving departmental performance but not for communicating with customers.

For a broad set of indicators, data are generally needed from a number of disparate sources. For example, a separate hospital department or third party may be the best source for patient satisfaction information, and the business office may be the best source for length-of-stay data. The manager should develop agreements with the necessary departments to obtain these data regularly. The task may be easy if the organization has a computerized data repository or if the department has a case management information system.

Generate easy-to-read reports

Once the indicators are selected and defined and a process is put in place to obtain data regularly, a report format should be generated. If a marketing or communications department exists, it should be asked to help develop a concise, easy-to-read report format. It is helpful if a small space is left for bulleted text comments about key milestones or exceptions to the graphic report. The comments should be short; if they cover more than 20% of the page, the audience may skip over the content. **(For a sample report template, see p. 95.)**

Customers or key stakeholders should have an opportunity to comment on the selection of indicators, report format, and, in some cases, operational definitions. This ensures that the instrument panel report will be both accepted by and familiar to the stakeholders. Discussion of the report also can create a common understanding of the challenges and barriers the case management department faces and the resources it needs.

The case management instrument panel (report) also can be used to engage the support and teamwork of staff members. The panel should be prominently displayed in the department and discussed at staff meetings, and staff should be encouraged to work as a team to make progress in all indicators targeted for improvement. In addition to challenging staff members, the report can be used to evaluate staff performance. Specific performance levels can be incorporated into evaluation tools to further motivate support for these customer-focused goals. Finally, the graphic report template can be linked to the data so any updates are automatically reflected in the graphs.

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CRITICAL PATH NETWORK™

Center for Case Management CareMap® Tool for deconditioned frail elders

The Deconditioned Frail Elder CareMap® Tool is designed to reflect the postacute continuum of care for patients experiencing deconditioning as a result of an acute medical event (i.e., pneumonia, CHF, etc.). **(See excerpts of the CareMap® Tool, pp. 88-90.)** These patients require time-limited support to return to a previous level of functioning in the least restrictive environment. This support may occur in that environment or in an inpatient facility. This decision is dependent upon the individual's needs, support systems, resources, and wishes. Regardless of where care is provided, the outcomes remain consistent.

The tool is intended to be individualized to reflect the patient's unique needs and requirements. Signature and date at the bottom of the intervention / outcomes section and initials next to the interventions in the appropriate day indicate completion of interventions or achievement of outcomes. If an outcome is not achieved, it may be circled and arrowed to the next 48 hour segment. If the patient is still unable to achieve the outcome, this signals the need for a patient / family / health care team meeting to reassess the appropriateness of the plan for this patient.

Editor's note: This month's Critical Path Network *appears courtesy of the Center for Case Management in South Natick, MA. It is reprinted by permission. For more information, contact the Center for Case Management at (508) 651-2600.* ■

New Web site is available for hospital information

QuadraMed Corp. of Richmond, CA, has paired with Health Forum, LLC, a subsidiary of the American Hospital Association (AHA) in Chicago, to provide a comprehensive Web site for hospital information. This partnership gives QuadraMed's American Hospital Directory Web site (www.AHD.com) select proprietary information from the AHA Annual Survey Database.

The Web site relies on public-use information from Medicare. The site enables subscribers to locate any acute care hospital in the United States that treats Medicare patients and track hospital characteristics and services, outpatient statistics, financial reports, inpatient utilization. ■

Share your pathway successes

Hospital Case Management would like to feature your work with clinical paths in our regular feature, *Critical Path Network.*

HCM welcomes guest columns about clinical path development and use. Articles should be written in an informal style with an emphasis on the practical details of pathway usage and should include any results (length of stay, cost, or process improvements) that use of your pathway has helped to achieve. The length of the article can range from 800 to 1,200 words.

Send article submissions to: Kimberly Coghill, editor, *Hospital Case Management,* P.O. Box 740056, Atlanta, GA 30374. Telephone: (404) 262-5537. ■

Patient History:
Allergies: Advanced Directives:
Special Needs/ Considerations:
[] Religious/Cultural Beliefs _____
[] Learning Style _____
[] Physical Challenge _____
[] Primary Language

Deconditioned Frail Elder CareMap®

PATIENT STAMP

met/date met/date met/date met/date met/date

DATE / PROBLEM/FOCUS	DAY ONE-TWO	DAY THREE-FOUR	DAY FIVE-SIX	DAY SEVEN-EIGHT	DAY NINE-TEN
1) Impaired Mobility	♦ No fracture or injury ♦ Patient/family participate in establishing target goal for mobility _____ ♦ Sits in chair 30 mins. BID ♦ Ambulates with assistive devices and supervision, 20 feet BID	♦ No fracture or injury ♦ Sits in chair for 30 mins. TID ♦ Ambulates with devices and minimal supervision ♦ Actively participates in therapy ♦ Demonstrates correct use of assistive devices ♦ States environmental modifications required	♦ No fracture or injury ♦ Negotiates stairs if needed ♦ Performs exercise program with cueing ♦ Actively participates in therapy	♦ No fracture or injury ♦ Demonstrates improved muscular strength and endurance ♦ Actively participates in therapy ♦ Demonstrates improvement of gait status	♦ No fracture or injury ♦ Target Goal Achieved_____ – ♦ Independent mobility or patient and family can manage immobility with necessary adaptive equipment
2) Self Care Defecit	♦ Patient/family participate in establishing target goal for self-care: _____ ♦ Actively participates in therapy	♦ Participates in upper body ADLs ♦ Manages medications with assist/cueing ♦ Actively participates in therapy	♦ Transfers to shower/tub with assist ♦ Completes upper body ADLs ♦ Self-care with toileting ♦ Actively participates in therapy ♦ Manages meds with supervision or independent	♦ Describes plan to manage meal prep/phone, money matters, shopping ♦ Completes ADLs with mimimum assist ♦ Actively participates in therapy	♦ Independent ADLs or patient/family can manage imparied performance ♦ State services to be received and date/time of MD follow-up appt. ♦ Manages medication
3) Potential Impaired Elimination • GI • GU	♦ Patient/Family participates in establishing target goal:_____	♦ Has BM ♦ Partipates in toileting schedule ♦ Limits evening fluid intake ♦ Demonstrates use of products to manage incontinence	♦ Has BM ♦ Partipates in toileting schedule ♦ Limits evening fluid intake ♦ Demonstrates use of products to manage incontinence	♦ Has BM ♦ Partipates in toileting schedule ♦ Limits evening fluid intake ♦ Demonstrates use of products to manage incontinence	♦ Has BM ♦ Is continent or demonstrates ability to manage incontinence
4) Anxiety	♦ Patient/Family address concerns and wishes to supportive staff	♦ Patient/Family address concerns and wishes to supportive staff	♦ Patient and family attend care planning meeting	♦ Patient and family state transition plan and timeframe	♦ Patient and family agree with transition plan/services
5) Altered Nutritional/ Hydrational Status	♦ States target calories, fluid intake and restrictions: _____	♦ Tolerates diet and fluids	♦ Reaches target goal	♦ Maintains target goal	♦ Maintains target goal +48 hours ♦ States menu options to meet goals ♦ Wt stabilized:____

Source: Center for Case Management, South Natick, MA.

DATE																	
PROBLEM/FOCUS	DAY ONE-TWO			DAY THREE-FOUR			DAY FIVE-SIX			DAY SEVEN-EIGHT			DAY NINE-TEN				
6) Potential for Altered Skin Integrity	♦ Skin will remain intact ♦Existing sores demonstrate granulation			♦ Skin will remain intact ♦Existing sores demonstrate granulation			♦ Skin will remain intact ♦Existing sores demonstrate granulation			♦ Skin will remain intact ♦Existing sores demonstrate granulation			♦ Skin will remain intact ♦Existing sores demonstrate granulation				
7) Patient's Specific Problem(s)													♦ Personal Important goal patient identifies: _____				

Source: Center for Case Management, South Natick, MA.

√ as completed

DATE															
INTERVENTIONS	DAY ONE - TWO	1	2	DAY THREE - FOUR	3	4	DAY FIVE - SIX	5	6	DAY SEVEN - EIGHT	7	8	DAY NINE - TEN	9	10
Assessments and Consults	♦VS qd ♦WT qd__/__ ♦BM noted & qd__/__ ♦I&O x 48^{0} ♦Assess Skin 4^{0} W/A ♦Calorie Count x 48^{0} ♦Home Safety____ ♦PT____ ♦Fall History____ ♦MD____ ♦Dietary ___ ♦SWS____ ♦Pharmacy____			♦VS ♦BM__/__ ♦WT__/__ ♦I&O____ ♦Calorie Count ♦Assess Skin 4^{0} W/A			♦VS ♦BM__/__ ♦WT__/__ ♦I&O*____ ♦Calorie Count*____ ♦Assess Skin 4^{0} W/A *I&O and Calorie Count may be stopped if acceptable			♦VS ♦BM__/__ ♦WT__/__ ♦I&O*____ ♦Calorie Count*____ ♦Assess Skin 4^{0} W/A *I&O and Calorie Count may be stopped if acceptable			♦VS ♦BM__/__ ♦WT__/__ ♦I&O*____ ♦Calorie Count*____ ♦Assess Skin 4^{0} W/A *I&O and Calorie Count may be stopped if acceptable		
Nutrition and Hydration	♦Establish target calories, fluid, restrictions ♦Determine patient preferences ♦Offer alternative menus ♦Small, frequent meals ♦Offer fluid 91^{0} W/A			♦Small, frequent meals ♦Identify primary meal provider ♦Offer fluid 91^{0} W/A ♦If incontinent, limit evening fluids			♦Small, frequent meals ♦Offer fluid 91^{0} W/A ♦If incontinent, limit evening fluids			♦Create grocery list ♦Repeat Calorie Count x48^{0} ♦Offer fluid 91^{0} W/A ♦If incontinent, limit evening fluids			♦Offer fluid 91^{0} W/A ♦If incontinent, limit evening fluids		
Safety and Mobility	♦Need for assistive devices addressed ♦Exercise program established ♦Target goal for mobility established ♦Physical Therapy initiated ♦OOB→chair bid ♦Ambulate w/ assist bid			♦Communicate required environmental changes to patient/family ♦Supervise exercise program ♦Ambulate with minimum supervision TID ♦OOB→chair TID x30 min.			♦Stair training if needed ♦Cue exercise program ♦Ambulate with minimum supervision TID ♦OOB→chair TID x30 min.			♦Ambulate with minimum supervision TID ♦OOB→chair TID x30 min.			♦Insure environmental modifications completed prior to discharge when possible		
Teaching and Support	♦Explore social supports and resources ♦Establish advanced directives ♦Inititae medication teaching			♦ Care planning meeting			♦Transition plan establish need for continued support of home health aide, homeworker, skilled nursing addressed			♦Explore etiology of acute event & potential preventive measures with patient & family → early S/S to report to careproviders			♦Reinforce education re: management and prevention of complications from medical problems		
Self Management (Medications included)	♦Occ. Therapy intitiated ♦Establish and review a method to access assistance ♦Bowel and bladder program established (medications, toileting schedule, moisture barrier, etc.) ♦Review meds & establish schedule/administration system ♦Personal care assistance ♦Establish target goal for selfcare_____			♦Review method to access assistance ♦Assess compliance and effectiveness of medication regimen ♦Cue for upper body ADLs ♦Personal care assistance ♦Assess effectiveness of bowel and bladder program			♦Review method to access assistance ♦Address meal prep, money matters, shopping ♦Transfer training to showare and tub with assistance ♦Assess compliance and effectiveness of medication regimin ♦Assist with lower body ADLs ♦Assess effectiveness of bowel and bladder program			♦Establish plan or community resources necessary to manage meal prep, phone, money matters, shopping ♦Assess compliance and effectiveness of medication regimin ♦Minimum assist for ADLs ♦Assess effectiveness of bowel and bladder program			♦Arrange for MD follow up ♦Assess compliance and effectiveness of medication regimin ♦Assess effectiveness of bowel and bladder program		

Source: Center for Case Management, South Natick, MA.

AMBULATORY CARE
QUARTERLY

Day rehab fills gap between inpatient, outpatient care

Patients receive 16-24 hours of therapy per week

Rehab facilities can fill a much-needed and reimbursable niche by providing a special rehab day treatment program for patients discharged from an inpatient setting but not ready for outpatient treatment.

HealthSouth of Birmingham, AL, decided to start this kind of program after noting a trend in which patients were being discharged from rehab hospitals with nowhere to go. Home health agencies and skilled nursing facilities once might have provided therapy services to those patients, but now they no longer have financial incentives to admit them, says **Lisa Combs**, RN, case manager of outpatient services and program manager of day rehab for HealthSouth Northern Kentucky Rehabilitation Hospital in Edgewood. The 40-bed hospital is a full-service outpatient provider.

"Our corporate offices saw a need for a program like this, given all of the federal Medicare cutbacks," Combs explains.

HealthSouth piloted its day treatment program at the Edgewood hospital, where the average daily census is 15 to 22 patients. The program provides a gentler regimen of therapy than a typical outpatient program provides, and it offers constant supervision. However, it cannot be mistaken for an adult day care center, where the emphasis is on supervision rather than therapy. Patients admitted to a rehab day treatment center might not stay the entire day, and they receive some level of therapy or education throughout their time in the center, even during the rest periods. "We felt we could offer a more consistent and better quality of care with our inpatients if they were discharged and followed through a day rehab center," Combs says.

CARF…The Rehabilitation Accreditation Commission, based in Tucson, AZ, began accrediting adult day programs in July 1999. The day treatment center offers patients a level of care that fits neatly between inpatient and outpatient services, she says. "In an acute rehab facility, patients will undergo therapy anywhere from 40 to 60 hours per week; in home care or an outpatient setting, they may get three to 10 hours per week. But by coming into a day treatment center, they are here for one-half to a full day, and they receive 16 to 24 hours a week of therapy."

Those patients need care and supervision that are more intensive than that offered by traditional outpatient programs, Combs says. Also, while it used to be an option to refer such patients to home health care or a skilled nursing facility, the Balanced Budget Act of 1997 greatly limited that option by cutting reimbursement for patients who had long-term therapy needs.

"Home health agencies and skilled nursing facilities can't afford to take these patients," Combs says. "We were being turned down with referrals, or the patients were discharged before they were ready for outpatient rehab care."

Another HealthSouth facility, HealthSouth Rehab Hospital of Central Kentucky in Elizabethtown, also has formed a day treatment program that is designed to suit the needs of patients who no longer require inpatient hospitalization and 24-hour nursing care but still have definable therapy needs, says **Angela Portman**, RN, day treatment coordinator of the 40-bed hospital.

"We look at this as a step down, a gradual process to community re-entry," Portman says. "A lot of patients have had strokes, and we have several traumatic brain injury [TBI] patients who are not safe to be home alone and have need for therapy."

TBI patients are a good example of patients who benefit from a day treatment program, Portman adds. "We've had several occasions where a TBI patient reaches the inpatient goal and is ready to be discharged, but to bring the person back as an outpatient would not work."

A TBI patient might come in for an hour of therapy and have to stay at the clinic, unsupervised,

waiting for the next therapy session. "Under the day treatment program, they would not be unsupervised," Portman says. "So this is for patients who have safety issues."

Patients typically attend the center three times a week for an average of four weeks, although some have stayed as long as 18 weeks. Once they are discharged, they can be referred to the outpatient setting for a continuation of therapies.

"But most of the time, they've gotten all the services they require and they're discharged completely," Combs says. "We have some patients who graduate from the day treatment center and come back here as volunteers." ■

Here are steps for starting a day treatment center

Programs can use outpatient facilities, staff

Rehab facilities interested in starting a day treatment program should tailor services to their expected client population, but there are some general guidelines to follow, according to rehab managers in charge of day treatment programs.

Angela Portman, RN, day treatment coordinator for HealthSouth Rehab Hospital of Central Kentucky in Elizabethtown, and **Lisa Combs**, RN, case manager of outpatient services and program manager for day rehab at HealthSouth Northern Kentucky Rehabilitation Hospital in Edgewood, offer these suggestions:

• **Use the infrastructure of your existing facility.** At Elizabethtown, the program was housed in the inpatient facility, but administrators decided to switch the program to the outpatient setting because it would allow more flexibility in staffing, Portman says. "When the inpatient census was high, the inpatient therapists had limited hours they could devote to the day treatment patients."

The day programs use the same staff as the outpatient programs, with the addition of nursing positions. This staffing arrangement means the programs have access to the full range of therapy, including physical therapy, occupational therapy, speech therapy, psychology, and nursing care. "If a day treatment patient needs two therapies, then we schedule them over three or four hours," Portman says. "If they need three or more therapies, we schedule them over five to six hours."

Between therapies, patients might rest or receive medical care. A day treatment program needs designated space, such as a room in which patients can relax between therapy sessions.

The Elizabethtown program has its own gym where staff can provide wound care and privacy for other procedures. The gym offers a home-type environment with a sofa, Portman says.

The Edgewood program has a living room, kitchen, dinette area, office, and bedroom. It's decorated with wallpaper and plants, and it has recliners that vibrate. Patients use the room to practice their homework, play games, play on a computer, receive medical care, or rest.

• **Develop specific admission criteria.** The Edgewood program was developed for patients with any type of neurological, orthopedic, respiratory, or general medical disability, Combs says. Some typical diagnoses admitted to the program include stroke, spinal cord injury, brain injury, asthma, chronic obstructive pulmonary disease, multiple sclerosis, Guillain-Barre Syndrome, traumatic brain injury, cancer, arthritis, and Parkinson's disease. Program criteria are:

— Patients must have identifiable rehab goals, with a purpose for coming to the program.

— Patients must be able to participate in the program without significant limitations of medical condition, decreased motivation, or lack of progress.

— Families should be willing to participate in the program and assist with discharge planning.

— Patients must be 14 years of age or older.

— Patients must require a minimum of two disciplines.

— Patients must have some type of medical management or endurance issue that necessitates the need for nursing or medical care. That issue can be anything from poor endurance and an inability to withstand three hours of therapy at one time to the patient's need for a blood draw, wound dressing change, or intravenous infusion or catheterization.

• **Establish hours, transportation, meals, and other details.** The program is open from 8 a.m. to 4 p.m. Patients who come in the morning receive breakfast, and those present at noon receive lunch. The program also provides transportation to patients living within a 30-mile radius who have no other means of attending. "One of the biggest benefits is the family can continue to do the things they need to do, and the injured person still gets what he needs," Portman says.

Along with meals, the program provides nutritional education by a staff dietitian as needed. "We also assist with activities of daily living if they need that help," Portman says. "We work in conjunction with an occupational therapist to provide transfers, baths, and that sort of thing while they're here."

• **Focus on marketing, reimbursement, and referrals.** When the Edgewood program began in July 1998, most of the referrals came from the inpatient program. Now the referrals are about 50% from the inpatient unit and 50% from outside the hospital. "We market it to the public through different events, such as a big block party that we held here last September," Combs says. "We had a disk jockey, dancing, a big cookout, and we invited the neighborhood to come." Discharge planners, patients, and staff hosted the party.

Other marketing events include open houses and speaking/educational engagements provided through a public outreach service.

Day treatment patients can be referred by family members, physicians, assisted-living facilities, home health agencies, skilled nursing facilities, and insurance companies, Combs adds. Medicare provides reimbursement for the program at a per therapy, outpatient rate. HealthSouth sometimes negotiates with insurers for a per diem rate. "We have contracts with several insurance companies," she says. ■

What's a typical day in a day treatment center?

Discharge planning begins at admission

Rehab day treatment centers are expected to grow rapidly in coming years, as the rehab industry looks for a way to treat patients who no longer need inpatient care but who are not ready for outpatient treatment. Day treatment program managers offer this look at a typical routine:

• **Day of admission:** A team of nurses and the medical director evaluate the patient's therapy results and determine an individualized treatment plan, Combs says.

"Some patients come three days a week, some come five, and others come four days," says **Lisa Combs**, RN, case manager of outpatient services and program manager for the day rehab program at HealthSouth Northern Kentucky Rehabilitation Hospital in Edgewood.

Discharge planning begins on the day of admission. The discharge planning team includes the disciplines of nursing, dietary, pharmacy, and therapy. The team meets weekly to discuss each patient's progress.

• **Typical day's schedule:** At Edgewood, the typical day might begin with a head-to-toe nursing assessment at 8 a.m. The nurse gives the patient any necessary medications and finds out if the patient has any complaints or concerns from the prior evening and day. Then the nurse reviews the patient's chart and goals and discusses strategies with the patient.

The patient might begin therapy at 9 a.m., first with an hour of physical therapy. At 10 a.m., the patient receives occupational therapy. At 11 a.m., the patient meets with the nursing staff. If the patient has a wound, the nurse provides wound care.

"If the patient is a diabetic, then we'd do a blood sugar check and we'd give them any education they needed for diabetes," says **Angela Portman**, RN, day treatment coordinator for HealthSouth Rehab Hospital of Central Kentucky in Elizabethtown.

At noon, the Elizabethtown HealthSouth patient eats lunch and rests. If the patient is tired, he or she may lie down or relax in a comfortable chair and watch television. Sometimes a group of day treatment patients will socialize or play games. No therapy is provided between noon and 1 p.m., Portman says.

At 1 p.m., the patient might receive speech therapy, and the day could end at 2 p.m., or the patient could stay for continued education and therapeutic activities.

• **Therapeutic activities between sessions:** The Edgewood program strongly emphasizes therapeutic activities that occupy a patient's time between therapy and nursing sessions. For example, a patient might have speech therapy homework assignments, and a nurse can help the patient with those. Or the patient might practice cooking or have a home exercise program that will be reviewed between therapy sessions.

"We do education and practice on diabetes, medications, and whatever their needs are," Combs says. "We do crafts and community reentry outings with them."

Patients may rest, but they have to keep active. "They have to do something therapeutic while lying in a recliner," she says. For instance, a patient might play with a dough-type product, called

"theraputty," which is therapeutic. "It's squishy and comes in different colors, and each color represents a different strength. You upgrade the theraputty as patients become stronger."

Using a rubber band with colors signifying different strengths, patients perform leg and arm exercises. Monopoly, card games, and jigsaw puzzles also may be therapeutic for cognitively impaired patients, she adds. "Jigsaw puzzles are wonderful. Will they remember to put the pieces on the outsides and corners first? Will they group colors together, knowing this is the sky and this is the grass? Will they use pincher mechanisms to connect one piece to the next?"

Patients may play computer games that hone skills in problem-solving, abstract thinking, and memory. "These are games like solitaire for patients with a profound deficit with short-term memory. Do they know how to sequence? Can they remember the ace moves to the top?" Computer games also might benefit physically impaired patients by offering some fine motor coordination activities, Combs says. ■

Report asks HCFA to review Medicare policy

The Health Care Financing Administration (HCFA) soon may be reviewing hospitals with a high number of Medicare same-day readmissions.

A report released in February by the Department of Health and Human Services' Office of Inspector General found that same-day readmissions were a cause of concern regarding quality of care issues, in addition to billing and overpayment problems.

The report, "Analysis of Readmissions Under the Medicare Prospective Payment System for Calendar Years 1996 and 1997" (A-14-99-00401), also recommended that HCFA:

- make the data in its report available to peer review organizations for use in determining the scope of their peer review activities;
- perform beneficiary-specific reviews on the claims of beneficiaries who had multiple continuous same-day readmissions;
- review a sample of same-day readmission claims in which the same-day readmission was coded with the same diagnosis-related group as the first hospital stay.

HCFA generally concurred with the recommendations but noted that only 61 providers had 30 or more readmissions in 1996 and 1997. HCFA will ask peer review organizations to investigate. HCFA, however, may suspend payment for same-day readmissions pending verification of their appropriateness. The full report is available at www.hhs.gov/progorg/oas/cats/hcfa.html. ■

'Next Generation Internet' is on the horizon

Increasing the public's use of the federal Internet database MEDLINE means increasing the budget for the Next Generation Internet (NGI) project in 2001, according to **Donald Lindberg**, MD, National Library of Medicine (NLM) director.

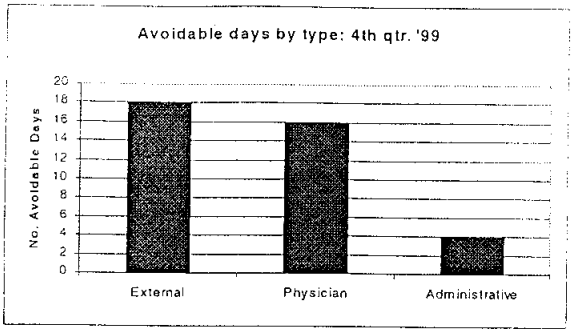
In a recent statement to the Subcommittee on Science, Technology and Space of the Senate Committee on Commerce, Science and Transportation, Lindberg said an increase in the NGI budget would, among other things, increase bandwidth for the MEDLINE, the library's database. Advanced medical imaging requires more bandwidth than is currently available on the Internet. Additional bandwidth would allow prompt diagnosis based on transmission of complex images.

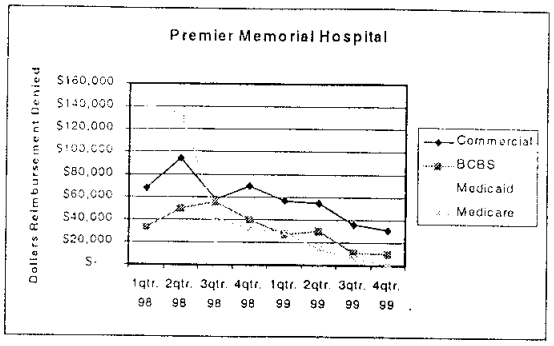
Another NGI improvement, Lindberg said, would be assuring protection of privacy among members of the public using MEDLINE. Other potential new applications for MEDLINE include home health care, continuing medical education, public education, and possibly even reduction of errors in medical practice.

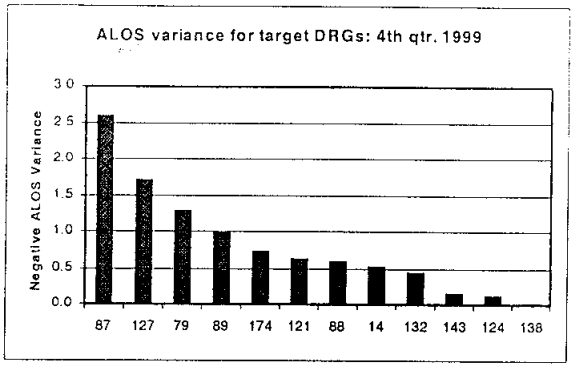
In the past four years, public use of MEDLINE has increased from 7 million searches a year to 250 million per year. Although widely used by scientists and health care workers, about 34% of Medline searches are performed by members of the public seeking information about their health.

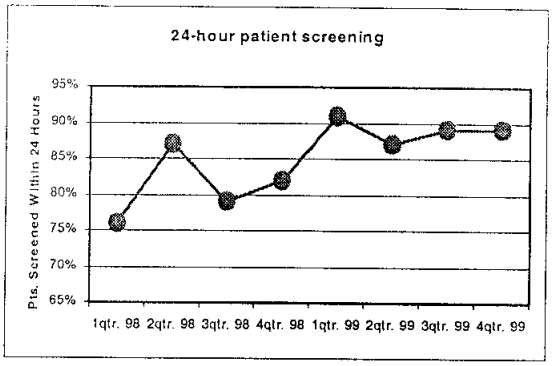
The NLM plans to support more than $45 million in NGI projects, including telemedicine projects, advanced medical imaging, and patient-controlled personal medical records systems, Lindberg says. For more details on this effort, see www.nlm.nih.gov/od/ngi2001testimony.html. ■

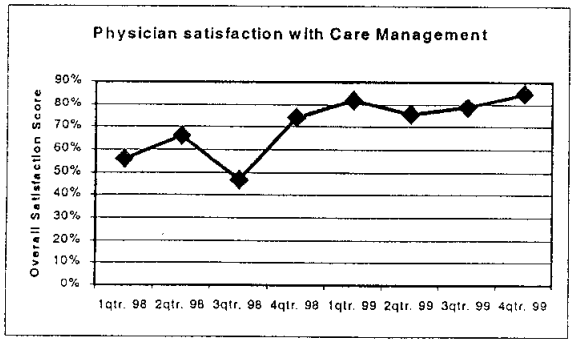
Care Management Report Card: 1st Qtr. 2000

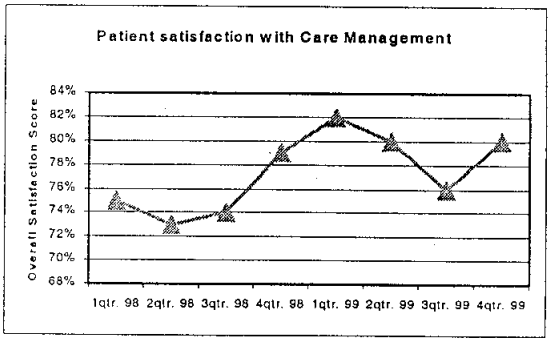












Comments:

- Hired one additional care manager to support neuro team.
- Multidisciplinary team formed to perform root cause analysis and develop recommendations for decreasing externally-caused avoidable days.
- Medical staff satisfaction reaches record 85 percent score.
- Began work with selected physician partners to minimize avoidable days.

Source: Premier, Inc., Charlotte, NC.

(Continued from page 86)

The case management instrument panel is a powerful tool for documenting the value that case managers bring to the organization. Not only can it be used to express the shared vision between customers and case managers regarding what the case management function is supposed to achieve, but it also can clearly show measurable progress toward shared objectives. Finally, the case management instrument panel can be used to strengthen both the case management department and the hospital or health system by focusing staff on common goals. ■

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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. ■