HOSPITAL CASE MANAGEMENT™

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

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Internal case management program gets injured employees back to work

Database helps track alternative jobs

An internal case management system for hospital employees who are injured on the job has reduced costs and increased return to work for Allina Hospitals and Clinics, based in Minneapolis.

The health system's disability case management program received the 2003 Quality Leadership Award from the Certification of Disability Management Specialists Commission for its disability case management program.

"The system is meant to help injured employees continue to work. Without these case managers, some employees could fall through the cracks and lose more time from work. It would be a lot more costly from a workers' compensation standpoint," says **Marsha Studer**, MPH, corporate safety and health director for Allina Health System.

Allina Hospitals and Clinics operates 11 hospitals and 65 clinics staffed by more than 23,000 employees.

The health system has on-site occupational medicine clinics staffed by nurse practitioners and occupational medicine physicians at its large hospitals, allowing injured workers to get care in minutes for injuries or exposures to potentially hazardous situations. The clinics also provide vaccinations and tests, such as annual tuberculosis screenings.

Accommodating workers via alternative jobs

The hospital's internal return-to-work program centers around an internal placement program that requires managers to accommodate employees with alternative assignments.

The managers enter any special projects they need help with or any opportunities for alternative work into an electronic database, giving the case managers quick access to jobs that are available.

"When employees have work injuries and can't do their regular jobs,

we can bring them back to work, whether it's light duty in their department, or other work in the hospital that can keep them on the job," says **David Dubovich**, one of the health system's three disabilities specialists.

Dubovich and his colleagues have offices in the occupation medical clinics, making them easily accessible to injured employees.

After the employees are treated, the internal disability case managers evaluate the employees for vocational and medical issues, help them navigate the complex claims system, and help them return to work.

Dubovich says he develops a rapport with the employee, often spotting barriers to effective return to work, such as relationships that are not working, or psychological stress that could interfere with the employee's return to work.

He may refer an injured employee who has mental stress to other resources, including the hospital's internal or telephonic employee assistance program for a referral to a counselor.

"An injury at work can be traumatic for the employee as it is disruptive of their normal routines at work and at home. When I talk to them, they may disclose other things that are going on at work or problems with their managers. I encourage them to call our employee assistance program for referral to a counselor. I assure them that the counseling services are confidential and voluntary," Dubovich says.

If an employee can't return to his or her regular job within a few days of injury, that person starts to work on alternative assignments. Dubovich acts as a liaison between the injured employee and his or her manager, encouraging them to communicate with each other and keeping the manager informed of the employee's return-to-work status.

"The managers appreciate having an outside party help them understand what's going on and to help create a plan of action to get the employee back to work," he says.

When Dubovich meets with an injured employee, he assesses the vocational status, such as transferable skills, career interests, functional abilities, work restrictions, and the hours typically worked and tries to find an appropriate alternative job.

Once the employees are on the job, the case managers monitor their follow-up appointments with their physician and find out how they are progressing medically and help in facilitating communication with the claims staff.

Smoothing out the return to work

When the employees are ready to take on some of their regular duties, the case manager develops a return-to-work plan that may include placing them in their regular job for a reduced number

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of hours and gradually adding duties each week to build up their capacity for more demanding work.

"We want the employee to have a successful return-to-work experience and to be able to work safely without further injury," Dubovich says.

The case managers work closely with the organization's internal placement specialists to accommodate patients who can't return to their regular job. "Sometimes when medical restrictions become permanent, the employee is not able to return to his regular job. Then our goal is to help the employee find a job in the system that puts their knowledge and expertise to work," he adds.

Sometimes employees who can't return to their regular job are hired permanently by the department where they were assigned to light duty.

In other cases, the case managers and internal placement specialist coordinate training for employees who might be able to move into a position that doesn't involve physical work.

For instance, the hospital offers seminars on communication skills, computer skills, and medical terminology, enabling employees to work in the call center or other sedentary positions.

They work with the employees on safety issues in their workplace in an effort to prevent future injuries.

For instance, if an employee comes in with early warning signs of tendonitis, the case manager may send him or her for an ergonomic evaluation and suggest ways to reduce the symptoms.

Dubovich's cases range in length from two weeks to several years if a patient has several surgeries and multiple attempts to return to work. The average length is about six months.

He works with complex cases on a daily basis, otherwise touching base at least weekly with his active cases. He typically handles about 100 cases a year.

Injuries catch up with older workers

The bulk of his cases are employees with neck, back, and shoulder injuries, something he attributes to an aging work force suffering from the cumulative effect of physically demanding work and a trend toward more obese patients who are difficult to lift.

"The hospital's internal case management program was begun in 1985 when a nurse with case management skills was injured.

"We were looking for a placement for her and decided to ask her to help with return-to-work support and coordination. That was the beginning of our case management program," Studer explains.

The current program is staffed with case managers with a vocational rehabilitation background, she notes.

"They are familiar with all kinds of different jobs and work accommodations. They are able to match the employees with jobs suited to their skills if they need alternative types of work," Studer adds. ■

CMs, quality managers team up for better care

Technology helps staff take proactive measures

Merging the case management department with the quality department is "the best thing we've ever done," says **Sharon Simmons**, CRNP, MSN, CNOR, director of clinical excellence for St. Vincent's Hospital in Birmingham, AL. Combining the departments has resulted in a tremendous improvement in quality of care as well as improved outcomes, she adds.

When the two departments at the 338-bed hospital were combined a year ago, the case managers and social workers were assigned by service line, reporting to an outcomes manager who is responsible for all quality initiatives in that area. The medical staff, process improvement staff, and peer review staff have been divided among the same service lines. "Now the case managers can spend more time with the nursing staff, the physicians, the physical therapists, pharmacists, nutritionists, and other people on the patient care team, making sure they're all on the same page," she says.

For instance, working with physicians to improve documentation, the case managers have helped increase the hospital's case-mix index from 1.3 to 1.54, resulting in a substantial increase in Medicare reimbursement.

When data showed the intensive care unit's cases of ventilator-acquired pneumonia were three times the national average, the case managers instituted an intensive process-improvement project, working with the nurses to make sure the proper procedures were carried out for each ventilator patient, helping the nurses organize the questioning procedures on each patient, and educating

the nurses on what they should do.

As a result, the hospital went more than six months without a single case of ventilator-acquired pneumonia. The results were so impressive that the Institute for Healthcare Improvement, based in Boston, asked the team to present its ventilator-acquired pneumonia data at the IMPACT Spring Learning Session.

Before last year, case management was a separate department that included social services. The case managers performed utilization review and were starting to work on documentation and coding with physicians. "They were operating in their vacuum, and we were in ours," Simmons says.

The quality department coordinated quality and process improvement initiatives, such as collecting data for the Joint Commission on Accreditation of Healthcare Organizations and Centers for Medicare & Medicaid Services core measures.

"The case managers are out there on the floor and are the eyes and ears of the quality people. Instead of having a few people controlling quality, we have a big department that can look at and run data and be on the front line talking to the physicians and nurses. It's been a really good thing for the hospital," Simmons explains.

A state-of-the-art technology system is the heart of the case management and quality management initiatives because it frees up the staff to take a proactive approach, she notes.

St. Vincent's was named one of the 100 Most Wired Hospitals in the country by *Hospitals & Health Networks*, the journal of the American Hospital Association.

Most of the hospital's charts are completely online. The hospital is an alpha test site for a new computerized physician order-entry system.

"We hope that by the end of next year, we will have eliminated paper charts. We're rolling it out now. The concept has been endorsed by The Leapfrog Group and other health care safety organizations as a way to prevent errors," says Simmons.

The case managers and social workers use the MIDAS+ care management system software from Affiliated Computer Services (ACS), a Dallas-based information technology firm. In addition to computers in their offices, the case managers have their own space with a computer on the unit. They also have access to computers in every patient room.

"Everything from concurrent review information for insurance or reimbursement to assessment information and discharge planning needs is all in the system. It gives us a seamless system that saves us a lot of time," she points out.

For instance, if a patient is transferred to a different floor or unit, the system automatically sends all of the patient information into the worksheet of the case manager, who will take over the patient's care.

"It enables us to go back quickly and look for information we need without having to request the records and charts and read through a lot of documents," Simmons says. For instance, when patients are elderly, they may be confused about previous admissions or treatments. The hospital has more than 10 years of records in its archives, giving case managers instant access to all patient information.

The software gives Simmons' department a quick way to run charts, looking at physician practice patterns, length of stay, and other outcome data.

The system allows the nurses to check off daily tasks such as holding a family conference, ordering durable medical equipment, talking to physicians about coding, interacting with the insurance company, reviewing charts, and discharge destinations of patients. At the end of the month, Simmons can pull reports showing how productive the nurses have been.

"These reports help me keep or gain my FTEs [full-time equivalents]. I can show how many people were placed in a skilled nursing facility or discharged with home health. All the case managers have to do is point and click on the screen when they enter their input," she says.

The charts allow Simmons to show the administration how many days the case managers saved in getting the patients discharged and tie the data to the decrease in length of stay.

The hospital's quality department uses software from Philadelphia-based CareScience and creates reports using financial and outcomes data, risk-adjusting the data based on a model within the software. Among the reports are lengths of stay by physician and by diagnosis-related group (DRG).

"The risk-adjustment factor eliminates people saying that their patients are sicker than anyone else's. We're not just telling Dr. A that his length of stay for the same diagnosis is longer than Dr. B's. We're telling him, 'Based on risk adjustment, your patients are staying longer than they should,'" Simmons adds.

The teams meet with the physicians monthly to share data on the top DRGs and the JCAHO core measures and look at documentation issues.

The software allows the team to show how many patients each physician has treated and how they are doing on the indicators. The data compare physicians to their peers, to the physicians in the CareScience database, and the national averages posted by JCAHO, she says.

"We are able to do physician profiling and create reports for the person who wields the pen and orders the patient care. That's how we can truly get change. We're increasing the quality of care and the safety of patients," notes Simmons, adding "when you improve quality of care, revenues go up and costs go down."

The case managers use the data to work closely with the physicians to improve documentation.

"Using the CareScience data, they show them how important it is to put patients in the proper DRG," Simmons says.

For instance, when the quality team looked at the data for pneumonia, it appeared that the hospital's mortality for simple pneumonia was statistically significant, but when the team examined the chart, it was able to clearly show that many of the cases, with appropriate documentation, should have been coded as a higher-weighted DRG that would have reflected how sick the patient really was. "The case managers were able to show the physicians that we looked bad because we were not documenting properly," she adds.

Spotting trends early

Because they are on the floor all day, every day, the case managers often see trends before they show up in the reports. "Now we're able to be more proactive in live time," Simmons notes.

When the case managers are on the unit, they use their computers to communicate with the outcomes managers and ask them to look at the chart, helping catch problems that otherwise might fall through the cracks.

For instance, if following discharge after surgery, a patient is readmitted to the hospital with a diagnosis of anemia, the case manager can call attention to the quality staff and determine if something was missed in post-surgical care.

"Even if they think the patient is being treated appropriately, they can ask them to watch for certain things," Simmons explains.

Because they spend most of their day on the unit, the case managers create a close working relationship with the physicians, accompanying the physicians on rounds. "It's not like a utilization review person from the outside is making rounds with the physician. Having the case managers on the unit makes it more of a team approach," she says.

The case manager runs the unit's care planning team. Based on patient population, the team meets either daily or two or three times a week. The multidisciplinary team includes nursing, physician therapy, occupational therapy, pharmacy, and everyone else involved in patient care, except physicians.

"They discuss what is going on with the patient from every different aspect. They look at what is the appropriate level of care and what they can do to move the patient to the next level of care," says Simmons. Some physicians have asked to join the care planning team. In addition to analyzing sentinel events, the hospital is analyzing near misses.

When someone on the hospital staff reports an incident in which a potential adverse event was avoided, the outcomes managers put together a team of everyone who was involved and look at how the process failed and how to prevent it from happening again. "We work on preventing problems before they happen rather than analyzing them afterward. With the computerized system, we have the time to do this," she adds.

When a case manager comes into the office each morning, she logs onto the MIDAS system and gets her work list, including patients she saw the previous day and needs to see again and any new patient moved to her floor overnight.

Case managers can enter reminders into the MIDAS system about things they need to do each day, such as cases that need discharge planning, utilization review, or documentation. The system allows them to set priorities on who they should see first. For instance, patients who are not meeting insurance criteria to remain at the hospital or those who will be discharged soon are given priority.

After the case managers get their day organized in the office, they go onto the floor where they can log onto the MIDAS system and have access to patient information as they visit the rooms. "By being unit-based, they build relationships with nurses and let them know what's going on from a quality standpoint," she says.

For instance, on the medical-surgical floor, it appeared the nursing staff were not meeting the benchmarks for educating patients on smoking cessation. The case managers determined the nurses were completing the education but not documenting. The information technology staff tweaked the computer so nurses have to document or they can't go to the next screen. ■

CM is the glue holding the trauma team together

Duties include coordinating care, helping families

The trauma team at Borgess Medical Center in Kalamazoo, MI, refers to **Dorothy Malcolm**, RN, BSN, as "the glue that holds us all together." As trauma case manager, Malcolm coordinates care for trauma patients from the time they come into the emergency department (ED), during their entire stay in the hospital and while they are being treated in the outpatient follow-up clinics.

"My job entails making sure the patients and their families needs are met and coordinating with the multidisciplinary trauma teams to ensure that all bases are covered," she says.

She coordinates care for traumatically injured patients, no matter what unit they are on. The hospital also has care managers, assigned by floor, who handle traditional case management duties such as discharge planning, utilization review, and coordinating with the insurance company.

Malcolm works with the care managers in the critical care units and on the neurology and orthopedic floors, coordinating the care of their traumatically injured patients.

"As a team, care manager, trauma case manager, and medical social worker, we can meet with the families to answer their questions. The care managers deal with the insurance piece and may bring up real questions for families in regards to different facilities and equipment. This gives us an opportunity as a team to explain the differences in facilities, what they have to offer, and what might work best for the patients and their family," she explains.

Malcolm coordinates all the clinical needs of the trauma patients and usually carries a caseload of 15 to 20 patients. She attends rounds with the multidisciplinary treatment team each day and helps develop the plan of care and the patient's treatment plan for the day.

Covering the bases

Following rounds, Malcolm makes a list of what each patient needs that day. She coordinates with members of the trauma team to make sure everything that was discussed happens.

"I'm the team captain, making sure each person on the team has covered their base, keeping the plan of care on track," she says.

Malcolm works from an office in the critical care unit and is paged along with the rest of the team when a patient comes into the ED.

"If I am in the hospital, I report to the emergency room almost every time. I'm usually the scribe nurse in the trauma room. If the family is available during the resuscitation of the trauma patient, I make contact with the family to provide them with some initial information and to let them know that the physician will see them when he or she can get away. It gives them a little bit of relief that someone has come and talked to them, and it also gives them a face they will see again during their loved one's hospital stay as I will attempt to meet with them on a daily basis." she says.

Communicating with, educating patients

Meeting with families and helping them understand what the patient's injuries and potential outcomes after discharge is a major component of Malcolm's job.

"I make every effort along with the other people on the trauma team, such as medical social work and pastoral care, to facilitate not only patient care needs but also their families' needs, whether it's housing at our hospitality house, help with insurance paperwork, or just a shoulder to cry on," she says.

Malcolm meets with the families sometimes on a daily basis, giving them updates on the patient's condition, the plan of care, and what outcomes they can expect. She talks to them about discharge options and educates them on what to expect if the patient is discharged to a rehab center or skilled nursing facility.

"Families with a critically injured loved one see so many people who bombard them with information. I'm the one person they see Monday through Friday. I give them a face and a name to go to for information," Malcolm adds.

As the patient progresses, she coordinates family meetings with the trauma surgeon, neurologist, neurosurgeon, social workers, or other appropriate members of the care team.

Later, Malcolm visits with the families to make sure they understand what is going on with the patient and helps them begin the coping process. "It's really hard for family members and patients to understand everything that is happening.

(Continued on page 159)

CRITICAL PATH NETWORK™

Joint replacement CM helps hospital improve outcomes

Surgeries increase, LOS, readmission rates decline

Hiring a case manager assigned specifically to manage joint replacement patients has paid dividends for St. Mary Medical Center in Langhorne, PA.

The number of total hip and total knee surgeries has increased from 145 in fiscal year 2003 to an expected 260 during this fiscal year.

During the same period, lengths of stay have dropped by 0.3 days, the readmission rate has declined by 1%, patients being discharged to home has increased by 10%, and postoperative deep vein thrombosis (DVT) and infection is down 0.3%.

The hospital started its orthopedic program a year and a half ago and added the case management component in November 2003, collecting baseline measures before the case management program started.

At the same time, the hospital created a dedicated orthopedic unit, instead of scattering orthopedic patients throughout the hospital, wherever a bed was available.

"The increase in the number of cases began just after we created the case management program. We haven't increased the number of orthopedists. Rather, improving efficiency and putting the patients in one unit has really worked to help our orthopods bring more of their cases to St. Mary," says **Steve Meurer**, MBA, MHS, PhD, vice president of operations.

Donna McNeill, RN, BSN, orthopedic case manager, starts working with total knee replacement and total hip replacement patients as soon as they make the decision to have surgery. She coordinates the care for hip and knee replacement patients, working closely with the physicians and their office staff and conducting all the preoperative training and orientation for the patients.

McNeill starts the patient educational process as soon as someone is scheduled for surgery. She invites the patients and their families to preoperative classes in the gymnasium, where they meet the physical therapists and occupational therapists and familiarize themselves with the equipment they'll be using after surgery.

"We show them what to expect and do as much as we can to allay their fears," she says.

In addition to talking with the patients and their families about what to expect during and after surgery, McNeill has compiled educational materials into a binder. Included are frequently asked questions, what to do before surgery, what to expect during and after surgery, signs and symptoms of postoperative problems, and other information. The binder contains preoperative exercises to help patients strengthen their muscles and precautions to take after surgery, and information about how the family should prepare the home for the patient's discharge, such as moving wires and loose rugs out of the way.

"The patients get so much information that they can't absorb it at once. That's why the binder is so important," she says.

McNeill starts the discharge planning process ahead of time so patients will know what options they have after surgery.

"They know they could go home, to a subacute facility, or an acute rehabilitation center, depending on how well they are and what their insurance covers. They're able to make plans ahead of time so it's not a shock after surgery," she says.

Many patients prefer to go to home or to an acute rehabilitation unit, an option few insurance companies cover for joint replacement patients.

If a patient wants to pursue the acute rehabilitation option, McNeill does an evaluation and applies for insurance certification ahead of time, reminding the patients that their insurance company may turn down the request.

"I help them realize how many people can go home and do well, and the majority can go home with no problems. A lot of it is knowing what to expect," she says.

McNeill visits patients every day they are in the hospital, reviews the chart, and makes sure the laboratory reports and other information the physicians need are included. She communicates daily with the physical therapist, the occupational therapist, the nursing staff, and the physicians.

"I try to help coordinate things and make sure there are no problems," McNeill adds.

Everyone in the orthopedic department meets once a month to look at what works and what needs improvement.

"The bottom line is to have the patient have a better outcome. We are constantly working to make sure the department runs smoothly," she says.

McNeill has created a form that keeps everyone in the hospital informed when a patient is scheduled for admission. The form includes date of admission, procedure, physician, information on the home environment, past medical and surgical history, and the probability of the patient being discharged to home.

The form is distributed to the home care coordinator, rehabilitation administration, and social worker, letting them know what patients are coming in and what to expect.

"This way, everybody knows about the patient and can get ready for him or her. The home care coordinator starts getting everything the patient will need set up ahead of time so there is no issue with that," she says.

The informational form includes a full evaluation of the patient with information about the home environment. "It gives the therapist a better picture as to what their goals should be. If a patient has to go up seven stairs to get into their home, the therapist will work a little harder on stair climbing than if they have to go up one step," she says.

When McNeill started the case management programs, she visited the home care agencies with one of the orthopedic physicians, told them about the program, and worked with them on a protocol to help them understand the goals of the program.

She created a continuum-of-care notebook that includes space for notes by the hospital's physical therapists and occupational therapists that the home therapist can review.

"This gives the home therapist information on what the patient can or cannot tolerate so they can continue therapy at the same rate rather than having to ask the patient. We are trying to make sure that the patient goes forward once they leave the hospital," she says.

Community education

McNeill offers free seminars on hip and knee pain to the community. She discusses what can cause joint problems and reviews various treatment options.

"A lot of times, people rely on the advice of their friends with similar problems. I tell them they need to see a specialist because their pain could be caused by a lot of various conditions that have similar symptoms," she says.

The orthopedists who work with the hospital give the people who attend the seminar preferential appointments.

"This program has made the hospital's orthopedic program more attractive to the doctors and to the community. When the doctors see the program we've put in place, they want to bring their patients here. They know that the more educated the patients are, the better the results will be," she explains.

Like all other hospital departments, the orthopedics department participates in St. Mary's intensive quality improvement program, Meurer points out.

"We have an unwavering focus on measurement and giving a department as much data as possible. We also are adding resources, such as case managers, to help get things done," he says.

One person in the performance improvement department gathers data from all departments at the hospital and develops charts for each of the indicators tracked for that department.

Each department receives a report card each month containing indicators under the topics of quality, service, financial, people, and growth.

The nurse manager or area manager use them to see in what areas the department is meeting goals and where it needs to improve.

The measurement team that supports each department also is involved in the quality improvement process.

The orthopedic program tracks postoperative

DVT, postoperative pulmonary embolisms, infection rate, percentage of patients going home, as opposed to a skilled nursing facility or rehab hospital, volume of patients, length of stay, readmission rates, the number of patients that McNeill sees on a daily basis, and patient satisfaction.

"We're very into patient satisfaction. Just two years ago, the hospital was just below the 50 percentile. Now we are consistently around 90%," she says.

When staff were asked why they believe patient satisfaction scores have increased, most of them said that the hospital is a happier place to work, Meurer adds. "While we have focused on quality and service, we have also focused on the fact that we need to be nice to each other," he explains. ■

Program enables 50 new initiatives in four months

'Transforming Care at the Bedside'

Seton Northwest Hospital in Austin, TX, launched nearly 50 new quality initiatives in a single four-month period after deciding to participate in the "Transforming Care at the Bedside" (TCAB) program, which was launched by the Robert Wood Johnson Foundation (RWJF) in Princeton, NJ, and the Boston-based Institute for Healthcare Improvement (IHI).

The program, which targets bedside care on a standard hospital medical or surgical unit, aims to enhance the quality of patient care and service, create more effective care teams, improve patient and staff satisfaction, and improve staff retention.

Seton Northwest joined the program in November 2003, recalls **Mary Viney**, MSN, RN, director of patient care services. "The process we used is what allowed us to complete nearly 50 initiatives in about four months," she says.

And just what did that process involve? First, she notes, having a large number of staff nurses on the core team was critical. Other members included pharmacists, two clinical managers, Viney, and a physician consultant. "Each one of the staff nurses took on two or three projects and led the changes, so we were able to work on several of them at one time," Viney explains.

It might seem that four months is not a lot of time to make significant changes, but she says several of the projects were quite successful.

Perhaps the most impressive project involved standardization of the post-op order sets. "Our gynecological surgeons took what they thought were our highest volume of cases and looked at their order sets as they came up to the med-surg floor," Viney notes. "Each of the 13 surgeons had their own hand-written post-op order sets." One of the nurses then took this on as a project, gathering all the different order sets, noting the common elements and the most frequently used best practices.

Once that was done, it was time to sell the new form to the staff. "We went to one of the physician champions," she recalls. "We told him it was more difficult for the pharmacy and nurses [to use the different handwritten forms] and noted the safety issue of legibility. He agreed to pilot the new form on one of his post-op patients."

All of this happened within two weeks, Viney adds. "The physician was quite open and used the form. Then we asked him to use it again the following day with two more patients. He said he had absolutely no concerns, that there were no changes needed on the new order set."

The team then asked the physician to go to the group in which he practiced and asked them to try the form. "They did so, and then he went to the whole OB/GYN section meeting and led a discussion about the need for change," she explains. "Within a month, we got 12 of the 13 docs to do it."

The new forms now are available in the recovery room, "all preprinted, so they are legible, and all consistent," Viney notes. This, in turn, allowed the pharmacy to create a standard record that could be entered into their computer. "And the nurses did not have to spend as much time transcribing," she says.

Viney notes that the new form has saved nurses between 18 and 20 minutes per patient — and has saved the pharmacy close to seven or eight minutes per patient. "It was safer, took variation out of the practice, and we were able to get more than 90% of the docs to use it in one month."

Subsequently, the same process was tried with total knee and total hip replacement surgeries. "We had two large surgical groups; we went to one surgeon, he tested the form, and it began to spread," Viney reports. In this case, 100% physician participation was achieved, as were similar time savings.

What was the key to success in this initiative? "We laid the issue out, gave examples of how the new forms looked and how similar they were to the old forms," she says. "We had to go through

the process, but they saw that we only changed maybe two or three things on the form, so they all agreed to it. Plus, this was a real predictable population, and they understood that. And in terms of staff, it's been a huge satisfier all around."

In addition, Viney says she was not required to wait for 100% buy-in before proceeding with the new process. "Before, we had to. Now, we can progress by little steps — that's part of TCAB." ■

JCAHO unveils national patient safety goals

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has released its 2005 National Patient Safety Goals that will apply specifically to hospitals.

The goals and associated requirements, which were approved by JCAHO's board of commissioners at its July meeting, include five of the 2004 goals and add two new expectations. The latter focus on reconciling medications across the continuum of care and reducing the risk of patient falls.

The goals set forth evidence-based requirements that address critical aspects of care known to involve significant risk to patients.

The goals are reviewed and revised annually by the sentinel event advisory group. This panel consists of physicians, nurses, pharmacists, and patient safety experts who work closely with JCAHO staff members on a continuing basis to determine priorities for and develop goals and associated requirements. They are largely, but not exclusively, based on information from the JCAHO sentinel event database. As part of the development process, candidate goals and requirements are sent to the field for review and comment before they are finalized.

The 2005 Hospital National Patient Safety Goals are as follows:

- **Goal: Improve the accuracy of patient identification.**

Use at least two patient identifiers (neither to be the patient's physical location) when administering medications or blood products; taking blood samples and other specimens for clinical testing; or providing any other treatments or procedures.

- **Goal: Improve the effectiveness of communication among caregivers.**

For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result read back the complete order or test result. Standardize a list of abbreviations, acronyms, and symbols that are not to be used throughout the organization.

Measure, assess, and, if appropriate, take action to improve the timeliness of reporting and the timeliness of receipt by the responsible licensed caregiver of critical test results and values.

- **Goal: Improve safety of using medications.**

Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride > 0.9%) from patient care areas. Standardize and limit the number of medication concentrations available in the organization. Identify and, at a minimum, annually review a list of look-alike/sound-alike medications used in the organization and take action to prevent errors involving the interchange of these medications.

- **Goal: Improve the safety of using infusion pumps.**

Ensure free-flow protection on all general-use and patient-controlled analgesia IV infusion pumps used in the organization.

- **Goal: Reduce risk of health care-associated infections.**

Comply with current Centers for Disease Control and Prevention hand hygiene guidelines. Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with health care-associated infection.

- **Goal: Accurately and completely reconcile medications across the continuum of care.**

During 2005, for full implementation by January 2006, develop a process for obtaining and documenting a complete list of the patient's current medications on the patient's entry to the organization and with the involvement of the patient.

That process includes a comparison of the medications the organization provides to those on the list.

A complete list of the patient's medications is communicated to the next provider of service when the patient is referred or transferred to another setting, service, practitioner, or level of care within or outside the organization.

- **Goal: Reduce the risk of patient harm resulting from falls.**

Assess and periodically reassess each resident's risk for falling, including the potential risk associated with the resident's medication regimen, and take action to address any identified risks. ■

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Clinic serves as a model for care of the uninsured

Volunteers play key role

In April 2002, **Donna Zazworsky**, MS, RN, CCM, FAAN, director of grants, partnerships, and policy at St. Elizabeth of Hungary Clinic in Tucson, AZ, got a telephone call from a case manager at a local hospital who wanted to know if the clinic had a hospital bed it could donate for use by a 17-year-old patient who was being discharged.

"She said they had a young man who was not insured, with a gunshot wound to the head, who had been stabilized after several weeks in the hospital, but who was paralyzed and still had a tracheostomy tube and a gastrostomy tube," Zazworsky explains.

The boy's mother was coming to take care of him, the case manager explained, but a hospital bed was needed, and she wondered if there was one available from the clinic's medical equipment loan chest.

"I said I could probably get a bed," Zazworsky recalls, "but then I asked her, 'Who is going to oversee his care?'"

That question, and its answer, set in motion a series of events, she says, that has everything to do with how discharge planners and case managers need to approach the problem of getting care for uninsured patients.

What the case manager told her, Zazworsky says, is that the young man had an appointment to come back and see a neurosurgeon in two weeks.

"Inside, I went nuts," she adds. "I said, 'Who is going to be there for the mother? She's the one giving care, and he has a trach tube, a G-tube, and a three-inch hole in his head? They need backup support. No one at the neurosurgeon's office is going to provide that.'"

While the Emergency Component of the Arizona Health Care Cost Containment System (AHCCCS), the state Medicaid program, had paid for the patient's initial care because his condition was life-threatening, Zazworsky learned, he didn't qualify for home health services because he was an undocumented immigrant. There was no primary care physician in the picture, she notes, because he had never needed one before.

"I told the case manager to have his mother come to the clinic, bring the papers we need — proof of work or a utility bill to show residence here and a photo ID — and said I would go out and do a home visit," she explains. Without her intervention, Zazworsky says, "I can guarantee you that he would have been in the emergency department [ED] in two days."

Instead, the coordination she provided through the clinic — using a myriad of carefully developed resources and affiliations — resulted in a program of care that was not only cost-effective, but far superior in quality to the reactive, stop-gap measures that otherwise would have comprised the young patient's follow-up treatment.

"The bottom line with discharge planning if somebody is not uninsured," she says, "is you need to really work on connecting people with a medical home that will provide primary care and case management to help people get through the system and to get them set up with a follow-up visit."

St. Elizabeth of Hungary Clinic, a nonprofit primary and specialty care clinic operated under the auspices of Catholic Community Services, serves individuals who are not eligible for federal or state-funded health care programs, Zazworsky explains. "They are the working poor, the recent immigrants and refugees." If the clinic's coordinated approach to care were used universally for the uninsured, she suggests, ED visits and overall costs would be reduced dramatically.

In the case of Daniel, the 17-year-old gunshot

victim, if she had not intervened, "the neurosurgeon would have followed through in some way, shape or form," Zazworsky says, "but what happens when I take over is that I start working with our volunteers. We got it done more efficiently and affordably."

Without that coordination, she adds, "he would have been in and out of the hospital many times, racking up a lot of bills."

In arranging care for the more than 18,000 active patients who are seen annually at the clinic, Zazworsky notes, she draws on not only an in-house administrative/provider staff of 52, but on 150 volunteer physicians, dentists, nurse practitioners, and nurses from throughout the Tucson community.

These volunteer practitioners, she says, either come to the clinic to provide care or donate slots of their office time. Among other arrangements with community providers, Zazworsky notes, a teleradiology set-up with radiologists at a local hospital allows St. Elizabeth's to send the day's X-rays to the hospital, where the physicians read the X-rays for free on their lunch hour and send them back to the clinic.

St. Elizabeth's contracts for laboratory services with another hospital, which maintains a drawing station at the clinic and gives its patients a discount, she adds. "They can get the lab done right there during their visit," Zazworsky says, after which the lab technician coordinates regular pickups of the specimens and takes them to the hospital and then sends back the results.

The ability to have laboratory services performed during a primary care appointment is an example of the kind of accommodation that is important in caring for the uninsured, she points out. "Most of our patients work low-income jobs and cannot afford to miss an hour or two. They might even be fired if they have to miss work. So one-stop shopping must be addressed."

Patients at St. Elizabeth's "have to pay for care," Zazworsky emphasizes. "It might be a $10 administrative fee. That's a big, important thing to get across. People need to keep their dignity for their well-being."

Fees are based on a sliding scale and are negotiated with the patient, she says. "We will bill them over time — even if they pay $5." In Daniel's case, for example, the family paid the $52 per round trip it cost for a specially equipped van to take him back and forth from the clinic.

The clinic gets some primary health care funding from the state: "a flat amount of money to provide care for the uninsured" that amounts to maybe $70 per patient (this includes the provider visit, lab, and other services), Zazworsky says. "It usually runs out in March or April, so from that time until about the end of June (the end of the fiscal year), we might bump up the fee."

"What happens," she adds, "is that you see our visits go down, because it's harder for people to pay, and ED visits go up." At present, Zazworsky adds, the evidence of that link is mostly anecdotal, but a local group of hospital administrators and business leaders is looking at doing an analysis of ED visits that would substantiate it.

"People can't be turned away at the ED," she notes. "They're either going there for a primary care visit that could have been done at the office; or they're not being cared for at all, and something more serious has happened; and they're going for that."

A cautious start

When Zazworsky left St. Elizabeth's to make that first visit to Daniel's home, she recounts, she took along the clinic's medical director, who looked at her and said, "Donna, we can't do too many of these." He was referring to the likelihood that the case would be very complex and require many resources, she adds, "and that was true in the first month. I made visits two or three times a week, and the medical director went weekly."

When they arrived at the tiny home in South Tucson, Zazworsky says, they found the mother, who speaks only Spanish, and her son, head bandaged, unable to turn on his own, and with the eyes of a deer caught in headlights. But having thought they might find the young man in a coma, she adds, they were thankful to see that "He was all there."

Zazworsky set about coordinating some care into the home, she says. "The mother knew how to manage the wound and was somewhat comfortable with the tubes but certainly not independent. I called a home health company I know, and they sent out a respiratory therapist who put in a talking trach. So then he could talk to us."

Discovering that Daniel could not yet tolerate bolus feeding, whereby a cup of tube feeding is put directly into the stomach through the G-tube, she asked for a nutritionist and a kangaroo pump that would deliver the food slowly in measured amounts.

"We needed to find out if he would have

enough calories and fluid for healing," she adds. "He was on a variety of medications, so we needed to see if changes should be made based on the G-tube route. I coordinated and oversaw all that."

Physical and occupational therapists, volunteers of the clinic, came out to do an evaluation, she says, and gave Daniel's mother instruction on basic exercises that should be done daily to reduce muscles contractures that occur when muscles are not used because of paralysis.

His mother, meanwhile, was calling the clinic regularly because she understandably had a lot of questions, says Zazworsky, who ended up giving the woman her cell phone number to facilitate the communication.

To make it easier to oversee Daniel's care, she asked the Arizona Telemedicine Program — which provides services to communities throughout the state from its base at the University of Arizona College of Medicine — to set up a unit in the home "so we could call him up and I could assess him from the clinic," she notes. "He thought that was so cool. He said, 'Donna, it's like [the television show] 'Big Brother.'"

When she discovered that the family had only a cell phone, Zazworsky adds, "I had to back up a few steps and call the telephone company and get a phone jack put in."

Once the telemed was put in, Zazworsky adds, "they managed very well. I went out every other week and then monthly. The medical director would come out if needed."

When she wanted to have Daniel hospitalized to have his tracheostomy and gastrostomy tubes removed, AHCCCS couldn't pay for it because it wasn't an emergency, she says. So Zazworsky arranged to have the procedures done by volunteer physicians at an outpatient clinic.

Later, she was able to get Daniel a "scholarship" through the foundation of a local rehabilitation facility, she notes. "They gave him five inpatient days where they taught him and his mom how to work better together — how to transfer from bed to chair, how to dress, daily living skills."

After Zazworsky made some contacts and assisted with paperwork, Daniel was able to enroll in classes through the home program of the local school district, she adds, using computer, television and the Internet to keep up with his studies.

Daniel's case "is such a classic story of how you have to work the system," she says. "He was somebody who could easily have been dropped. We picked up [his care] in April 2002, the tracheostomy and gastrostomy [procedures] happened that April and May, and then we got his head closed that August. Now we don't have to spend much time on him. He's a healthy young man — he just has this brain injury — and the most amazing person."

Although St. Elizabeth's is a faith-based clinic and currently does not qualify for federal funds, Zazworsky points out, there are more than 700 federally qualified community health centers throughout the country that receive money from the federal government to care for the uninsured (http:ask.hrsa.gov/pc).

In most cases, she adds, the clinics have a case manager who knows how to leverage funding for optimal benefit.

"[Hospital] case managers need to learn where the resources are," Zazworsky stresses. "Caring for the uninsured takes a lot of coordination, a lot of support from people in the community."

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Uninsured cases increase in number, complexity

'We try to educate them'

Arranging care for uninsured and underinsured patients has become more complicated in the past four or five years, says **Jennifer DeCamp**, MSW, LSW, a social worker at Swedish Covenant Hospital in Chicago.

"It seems there are more patients who do not have insurance and more challenging cases of all ages," she adds. "It might be someone who is 64 and won't get Medicare for a couple of months, or, as with a patient I talked with today, a working woman who has health care insurance that pays 10% of the cost of her medicine and nothing else."

In the latter case, DeCamp notes, the woman already has missed several days of work, can't work for at least another week, but has to pay rent, utilities, and other expenses, not to mention

most of the cost of her medication.

DeCamp says she gave the woman information on how to request help from the Salvation Army, and the Chicago Department of Human Services.

There are a number of patients who are in the country illegally, she says, and so don't qualify for coverage under any of the state or federal programs. "We'll see patients and treat them, but after discharge, if they need follow-up care, they usually get it at the public health hospital."

She also deals with foreign patients who become ill while visiting the United States, DeCamp notes, as was the case with a recent stroke victim whose care became extremely problematic.

"The patient, who is in his 40s or 50s, needed a hospital bed, G-tube feeding, and a special mattress on the bed to prevent skin breakdown," she explains. "In cases like that, we work a lot with durable medical equipment [DME] companies. They are able to get us some breaks when people are so low-income."

If the patient had been living and working in this country, he would have qualified for public aid, DeCamp notes. Although he had been visiting family members here, they were unable or unwilling to take him home after his hospital stay, she points out. "They said they couldn't afford it."

That patient, she says, stayed in the hospital far longer than his medical condition warranted, simply because there was nowhere else for him to go.

Getting the family involved

DeCamp says she has noticed that in many cases there seems to be a lack of any feeling of family obligation toward a patient who needs ongoing care. "It is the family's responsibility to care for their loved one," she says. "That's what people miss out on. If someone gets really sick, they need to step up and take care of them."

"We have a lot of nursing homes in this country, but if you don't have Medicare or public aid, they are not an option," DeCamp adds. "The only other option is to go home."

With that in mind, she adds, Swedish Covenant tries to give as much information as possible to patient and family. "I try to educate, to say, 'Here's what you're up against, here's what you can do, and here are tools to help you do it.'"

Exploring free or low-cost care options can take a lot of research and time, DeCamp continues, so in most cases social workers provide telephone numbers and addresses for resources, such as the city or state Department of Human Services or the Salvation Army, which may provide help with emergency housing, clothing, food, and medication.

The American Cancer Society has a used-equipment program, as well as other resources for those who need financial help, and the Alzheimer's Association has a family relief program, adds DeCamp. "Depending on the diagnosis, you can go to one of those associations."

"We have a patient right now who is going to turn 65 in a few months and has very bad wounds, is on intravenous antibiotics, and doesn't have insurance," she says.

"He is in that little pocket where — if he doesn't work and can't pay for his own care — we can't send a home health nurse. We will have to teach him how to do dressing changes and care for the wounds, make sure they're healing." DeCamp points out.

The patient's medicine will have to be taken by mouth, she adds, and if he continues to need IV antibiotics, he will have to stay in the hospital.

"There is also a company that provides specialized wound treatment equipment that has a benevolence program," DeCamp notes. "It takes a lot of paperwork and contact with the family."

Discounts also can be obtained from DME companies, she adds, and various agencies maintain DME lending closets. If the patient is terminally ill, hospice organizations are good sources of help for the uninsured, providing such things as pain medication, a hospital bed, oxygen or nursing support, DeCamp explains.

While Swedish Covenant provides a large amount of free care each year, there is a focus, she adds, on encouraging the patient to take responsibility for his or her own care once he or she is discharged.

"We're getting them started, but for follow-up, they need to take over," DeCamp notes. "We try very, very hard to prepare everybody not to anticipate that once they go home, they can depend on us to make all the necessary calls."

"We try to educate them to get in touch with the appropriate agencies on their own," she adds, "so if something breaks down, or they need help, they have more control."

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Sometimes, they can be told the same information from three or four different disciplines, but they hear and understand different pieces from each conversation. That is why family meetings are so important. We try to treat people like they are our own family, being honest, open, and realistic," she says.

Malcolm sees all of the patients who are on the trauma service daily, even those who are in the hospital only a few days, encouraging them to call her if they have any problems after discharge and before they come to the follow-up clinic. Giving the patients someone to call with questions helps cut down on readmissions, she explains.

Following up with patients

Malcolm follows up with the patients when they come into the trauma services clinic after discharge making sure they have made other follow-up appointments with whatever specialists they need to see.

When Malcolm comes into the hospital each day, she gets a list of new trauma patients from the hospital's computer system and then accompanies the trauma team on rounds.

"I attempt to see every patient prior to trauma team rounds or access their information to look at their last 24 hours in the hospital. This information is helpful in rounds when we are looking at progressing the patient's plan of care. For instance, I look for information on where they live. As we look at discharge planning, we want to place the patients close to home if that is their preference," she says.

Malcolm meets with the patients and families throughout the day, giving them updates on what is going on.

If a patient is being discharged, she makes sure they have prescriptions, discharge instructions, and other things they need.

If the patient is being transferred to a rehabilitation hospital or nursing home, Malcolm assists in getting the records transferred and assembles X-rays and other items that go with the patient.

She follows the patients through the hospital stay and while they are being treated as an outpatient, working with the team in the trauma service clinic, where patients come for outpatient care and follow-up after discharge. ■

CE *questions*

13. The bulk of cases handled by David Dubovich, a disabilities specialist at Allina Health System, include employees with:
    A. knee injuries
    B. sharps injuries
    C. neck, back, and shoulder injuries
    D. asthma

14. By working with physicians to improve documentation, the case managers at St. Vincent's Hospital in Birmingham, AL, have improved their case-mix index from 1.3 to 1.54.
    A. true
    B. false

15. The addition of a case manager for joint replacement patients at St. Mary Medical Center in Langhorne, PA, has resulted in what percentage increase in patients being discharged to home?
    A. 5%
    B. 10%
    C. 15%
    D. 20%

16. In what portions of the hospital does the trauma case manager at Borgess Medical Center work?
    A. emergency department and outpatient follow-up clinics
    B. orthopedic and neurology floors
    C. critical care units
    D. all of the above

Answer key: 13. C; 14. A; 15. B; 16. D

COMING IN FUTURE MONTHS

- Effective case management for the uninsured
- Redesigning your case management department
- CMS's Medicare Coordinated Care demonstration project
- Physician-centric case management

Revised recommendations for flu prevention issued

The Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP) has released its revised recommendations for the prevention and control of influenza. They update 2003 ACIP recommendations for the use of the influenza vaccine, including dosage and administration instructions, potential adverse reactions, and populations who should not be vaccinated, as well as the use of antiviral medications. Among its recommendations, ACIP says health care facilities should offer free, on-site vaccinations to all employees, including night and weekend staff, starting in October each year, with special priority given to workers who care for at-risk patients. It also advises acute care hospitals to strongly encourage patients who are 50 or older or have high-risk conditions to receive a flu vaccine before they are discharged.

For the complete revised ACIP recommendations, go to www.cdc.gov/flu. Go to the "News & Highlights" box and select "MMWR: Prevention and Control of Influenza: Recommendations of the Advisory Committee on Immunization Practices (ACIP)." ■

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. ■