HOSPITAL CASE MANAGEMENT™

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

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Pensacola hospital and patients survive battering by Hurricane Ivan

Hospital provided shelter to 2,000 people during the storm

It was about 2 a.m., Sept. 16, when Hurricane Ivan roared into Pensacola, FL, with 130-mile-per-hour winds, battering the boarded-up windows of Sacred Heart Hospital, knocking out the electricity and forcing the hospital to operate on emergency generators.

Many staff had arrived at the hospital before the storm hit, anticipating problems with transportation afterward, and they all sprang into action to make sure the patients and more than 2,000 family members of patients and staff being sheltered at the hospital were safe.

"It was pitch-black outside, and we heard the awful sound of that wind, but we couldn't see anything," recalls **Susan Kearney**, LCSW, manager of social services.

Although the windows were boarded up, staff were concerned they might buckle and decided to move the patients from their rooms and into the halls.

Prepare your hospital for a very unusual flu season

Vaccine shortages may wreak havoc with hospital EDs, absenteeism

With the unprecedented shortage of influenza vaccine this flu season, hospitals are scrambling to prepare for what may be a record number of flu patients presenting to their already overcrowded emergency departments (EDs) and for staff shortages due to record absenteeism. After almost half of the United State's planned vaccine supply was contaminated, high-risk candidates — including the very young, the elderly, those with chronic illnesses, pregnant women, the immunocompromised, and health care workers with direct patient care — have been identified as those to receive the vaccine.

In response to the national shortage of vaccine, Thomson American

(Continued on page 178)

Hospital staff were alerted and made their way through the darkened hospital. Within 15 minutes, all 360 patients who were left in the hospital had been moved to the hallways, with oxygen and IV lines still operable.

"The teamwork was amazing. People came from every department and every place in the hospital. Our primary aim was to move the patients and assure them that they were safe and well cared for," she says.

At the same time, the hospital staff became concerned about hundreds of visitors who were sleeping in the lobby, which had large, vulnerable windows. They woke them up and moved them to the basement, where it was quieter and safer.

The next few days called for creativity and patience on the part of the staff and patients, Kearney says.

The hospital regained electricity fairly quickly, but neither the staff's cell phones and pagers nor the hospital's e-mail system worked in the early days after the storm.

"The communication system was really challenged," says **Mike Burke**, public relations manager for the 449-bed acute care facility, which includes Sacred Heart Hospital, Sacred Heart Children's Hospital, and Sacred Heart Women's Hospital.

Managers and leaders from all over the hospital gathered every four hours in a central area to share information about what was happening.

"This is one of the most helpful things we did as a team. This allowed us to be in constant communication with each other, and we could take what we learned back to the staff who were hungry for information in a time of crisis," Kearney says.

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Marketing and public relations staff attended the meetings, typed up a summary, and walked through the hospital distributing them to all staff.

The hospital experienced minor damage but no significant structural damage. There was some flooding in the laboratory, caused by water backing up from the air-conditioning unit after the power shut down.

The first few days after the storm, the hospital didn't have water pressure or air conditioning and postponed elective surgery until the following Wednesday, Sept. 22.

"All of the essential functions of the hospital kept going during the storm. We delivered babies, did heart catheterization, and emergency surgery," Burke says.

In the two weeks after the storm, the hospital's emergency department (ED) visits went up by 40%. Among the injuries were 40 patients injured by chain saws and other serious injuries from falling limbs and falls. The Federal Emergency Management Agency sent a Disaster Medical Assistance Team to the hospital. It set up tents outside the ED to handle minor injuries.

As soon as the storm was over, the social workers and case managers started trying to determine which nursing homes could take patients who were ready for discharge and which patients could be discharged to home safely. They made calls to area grocery stores, pharmacies, home health care agencies, and durable medical equipment companies to compile a list of available resources for patients and employees.

They went over the list of patients ready for discharge on a case-by-case basis and thoroughly documented the medical records when the patients couldn't be released because they had no home to go to or no electricity and water. It took as long as 12 days for electricity to be restored to some parts of Pensacola and more than a week before the water was declared safe to drink.

The hospital still is waiting to learn whether the extra days will be covered by the patients' insurance. "We wouldn't have done it any differently. These patients couldn't go home and we have plenty of documentation as to why their discharge was delayed," Kearney says.

About a week before Hurricane Ivan struck the Florida panhandle, the hospital started preparing to implement its disaster plan and assigned duties for when the hurricane hit.

The purchasing department stockpiled food, water, medicine, and extra fuel for the hospital's generators, preparing for the possibility of being unable to have supplies delivered for a week.

Four days before the hurricane hit, the hospital began discharging as many patients as it could. Patients who were not ambulatory and who lived in areas that are vulnerable to flooding stayed in the hospital. "When discharges were postponed, we documented as carefully as we could as to the rationale," she says.

The day before the hurricane, the social workers and case managers shifted their attention to the duties they were assigned to handle during the storm. The social work department was assigned to staff the hospital day-care center during the time they were no longer needed for duties on the floor.

The case managers were assigned to the ED to direct people who did not need to be admitted to the hospital to special-needs shelters and other facilities. "We had a lot of frail elderly and people who were on oxygen who came to the hospital because they were afraid. The case manager's role was to direct these patients to appropriate shelters and assist in getting them safely to those shelters," Kearney says.

A shelter in the storm

During the worst of the storm, the hospital provided shelter for more than 2,000 visitors, including children of employees, other family members of employees, and families of patients.

About 20 women in the last stages of pregnancy came into the shelter and slept on recliners provided by the hospital. Several gave birth during the storm.

The hospital provided temporary shelter in its auditorium, the lobbies for the women's hospital and the main hospital, and in the long concourse areas connecting outlying buildings. Many staying in the shelter left the hospital shortly after the storm ended, but some remained for about five days. The day care operated for three weeks.

Kearney's first advice to hospital staff: Accept the fact that a disaster may happen and plan accordingly.

Although the hospital was well prepared for the storm, Kearney contends her department could have been better prepared. She would have stocked up on powerful flashlights, batteries, bottled water, and food for her department.

"Although the hospital fed employees at no cost for two weeks after the storm, we all wished we had planned ahead. We had little flashlights, and trying to make our way around a dark hospital

with those little lights was a real challenge," she says. "Prepare as if the disaster is going to hit you head-on," she adds.

Communication is the most vital part of preparation, and hospitals should prepare to operate without their usual communication equipment, she adds.

Make sure your staff have up-to-date information about where the shelters are, what kind of patients they can accommodate, and what kind of patients they can't take, she advises. ■

Team approach avoids denials and saves millions

Work cooperatively with business office, clinics

In 1999, Presbyterian Hospital of Dallas had a denial rate of 1.12% of gross revenue at year end. The denial rate began to decline steadily following the implementation of a denials management team and process improvement teams, both of which include members of the case management staff. The process has saved millions of dollars. For fiscal year 2003, the denial rate has dropped to 0.2% of gross revenue.

"Implementation of a denials management team and identifying where in the process we could improve to prevent denials has made a huge difference," says **Kathy Sorce**, MS, RN, FNP-C, clinical resource manager at the 866-bed facility.

The denials management task force is made up of representatives from departments responsible for admitting patients, coding patient data, assessing medical necessity of admissions and procedures, billing for services, and processing denials. The business office runs daily reports, and the appropriate department takes immediate action in each case, providing appropriate follow-up to overturn the denials. "We've seen a huge decrease in dollars denied in the last few years," she says.

As the business office receives denials, whether from insurance, Medicare, or Medicaid, they are coded as to the cause. The goal is to complete an analysis of the denial and, if the hospital submits an appeal to the payer, to do so in fewer than 30 days from the receipt of the denial.

Case managers are responsible for reviewing and appealing the medical necessity denials.

"Case managers often know that these denials will come in. Many times, there are already notes in the patient file that we agree. There may have been a patient or family or physician issue that kept the patient a day longer," Sorce explains.

Case managers write appeal letters for the denials, using a blank template and plugging in pertinent data, then attaching whatever parts of the medical record are needed.

The denials management task force analyzes trends in denials and suggests changes to correct any glitches in the process.

Representatives from case management sit in on the process improvement committees for each service line. The committees are made up of disciplines involved in the care of patients for that particular service line and include physicians, nurse managers, staff nurses, pharmacists, therapists, and an administrator.

"They are the clinical liaison link with what is going on, and they fill a vital role in process improvement," Sorce says.

For instance, the medical process improvement committee looks at issues involving how the patients move through the continuum of care. One problem the committee tackled was the number of patients whose lengths of stay were extended while they waited for their therapeutic anticoagulation status. The committee recommended establishing a coumadin clinic, which allows patients to be discharged early and go to the clinic for proper monitoring.

"The case managers often know where the delays are occurring in the hospital, and they are in a position to see where the process can be improved," Sorce continues.

Other process improvement teams include oncology, women and child services, surgical services, cardiology/cardiovascular services, and pain management.

"Part of what we look at is what's going on in terms of length of stay. Case managers can identify trends and know if we see an improvement in length of stay or see length of stay creeping up. They are able to respond to the questions about what is happening and what is being done," she explains.

The process improvement committee meets monthly or every two months, depending on the needs of the group. It looks at clinical indicators by the Joint Commission on Accreditation of Healthcare Organizations and the Centers for Medicare & Medicaid Services and works on improving compliance with the indicators as well.

One group looked at the referral process and how soon patients were getting consultation for

rehabilitation or skilled nursing facilities.

"These consults can result in a one- or two-day delay. We have focused on the discharge planning process to make sure that the nursing units, in coordination with social work and case management, are doing discharge planning rounds in the best way. We hold the staff and the case managers accountable for managing length of stay," Sorce notes.

Three years ago, the hospital had only five utilization management coordinators for the whole facility. The utilization management coordinators worked with the insurance company on continuing stay review and authorization so the hospital was assured payment. Clinical documentation specialists were responsible for reviewing the documentation of the physician and making sure the documentation represented the resources used.

"It wasn't enough. We expanded the program out of necessity to be able to truly manage the patients' length of stay and their needs while they are in the hospital," she says.

The hospital redesigned the program, combining the utilization management and documentation roles and cross-training the staff to perform both roles.

"It didn't make sense to have one person reviewing the chart for appropriate documentation and another for medical necessity. The previous design was a more narrow focus than true case management in terms of managing care, working with physicians and ancillary staff, and making sure the patients received the care they needed in a timely manner," Sorce adds.

Now the hospital has 17 case managers who are assigned by service line. The hospital's social workers team with case management to manage the patients' lengths of stay and handle discharge planning. On a daily basis, case managers run a work list of patients in their area. They are responsible for admission and continuous stay review. They make sure all new patients meet admission criteria.

They handle an average of 30 to 35 patients at a time and set priorities based on patient conditions, diagnoses, and anticipated length of stay. They attend discharge planning rounds on their units.

"The case managers are one of the driving forces in discharge planning. They talk to the staff nurses to find out how the discharge planning is going and to assure that the patient will be discharged when they need to be. In cases where the patients have needs in the community, they collaborate with the social work staff," she points out.

Four case managers are assigned to the hospital's cardiac program, two each to surgery and medical and two to orthopedic surgery.

The case managers are based near the nursing unit. If a patient is transferred from one unit to the next, the case manager hands off the case to her colleague on that unit.

"It's working well. We've been able to reduce the caseloads of the individual case managers. They're able to review cases on a timely basis," Sorce says.

The department tracks the number of retrospective reviews it has to do following a request for information from payers.

"We've seen a dramatic decrease in retrospective review and medical necessity denial. The staff are on top of any cases where it looks like there is a potential for denial," she adds.

The case managers turn in a case sheet at the end of every case and report on a monthly basis.

At Presbyterian Hospital of Dallas, a lot of the work done by the care managers is manual. A patient management system has a place to enter free text notes to describe exceptions or problems, such as difficult cases or insurance issues, Sorce says.

"We have adopted some other measures, such as denials that we track. I can run an automated report on the back end and see where there are avoidable days and denials," she says.

Working with case management teams from 12 other hospitals in the Texas Health Resources System, Sorce and her staff are in the process of helping evaluate vendors for a systemwide case management electronic record system. Target for implementation is 2005.

"With a true electronic record, you can see not only this episode of care but can look at a longitudinal basis and find out what health issues have previously been addressed and look more in depth than the current episode of care," she adds. ■

Get ready for emphasis on quality measures

Take a team approach to improve processes

Public reporting of quality measures is likely to increase in the near future, and hospitals should get ready, asserts **Carolyn Scott**, director of collaborative services and CEO work groups

(Continued on page 189)

Simple measures result in big quality improvements

Staff reminders, report cards are effective

When it comes to improving quality, sometimes the simplest and least expensive measures work best, reports **Earl Kurashige**, RN, project manager for Qualis Health, a nonprofit health care quality improvement organization based in Seattle.

Simple tools such as chart stickers and reminders can make a big difference in helping hospitals meet the Centers for Medicare & Medicaid Services (CMS) and the Joint Commission on Accreditation of Healthcare Organizations' quality indicators, he notes.

"We suggest simple reminders to prompt hospital staff to start paying attention to certain issues so that topic can be discussed with the patient," says Kurashige.

Qualis holds regional meetings with participating hospitals in the state of Washington and asks them to share their methods for successfully improving quality.

Sometimes driving improvement for a certain measure may be as simple as a sticker on the chart reminding the physician to write a prescription for an ACE inhibitor.

"Stickers that go on the chart are a very inexpensive way of reminding the staff of the quality initiatives. The staff who take care of the patients are very busy and have a lot of work to do. They may forget to do certain things, like cover smoking cessation with patients who need it. These reminders are simple, inexpensive, and effective," Kurashige says.

Qualis supplies hospital staff attending the conferences with pre-printed chart stickers that contain reminders for smoking cessation, mammograms, and immunizations and encourages the hospitals to print their own to remind staff of quality measures they are tracking.

"The stickers are very inexpensive. They can be printed for any quality initiative," he explains.

Hospitals that belong to VHA Inc., an Irving, TX-based health care cooperative, share order sets, patient educational materials, clinical pathways, and other processes used to improve quality, says **Carolyn Scott**, director of collaborative services and CEO work groups for clinical excellence at VHA.

"Most organizations have something they do really well, and we help them share their methods with each other," she says.

Developing standardized order sets goes a long way toward process improvement by ensuring that the quality indicators are met, Scott explains.

"It's not that the physicians don't know how to write an order, but it's a lot easier when they just check the boxes or draw a line through what they want or don't want done," she adds.

Here are some other tips from Scott and Kurashige on simple ways to improve quality:

- **Post data on the unit.**

Scott suggests posting information such as the time it took to get a heart attack patient to the cardiac catheterization lab or on thrombolytic therapy.

"If you can posts those numbers in the cath labs or emergency departments [ED], that helps drive improvement. It sets the bar within your own organization," she says.

By following this suggestion, many hospitals have been able to reduce the time it takes to get patients to the cardiac catheterization lab, Scott explains.

"By merely posting the data, an awareness of the process is created. The ED and cath teams then begin to work on improving the times to these important, life-saving interventions," she says.

The strategy works in other areas of the hospital where you're trying to improve a process, Scott adds. The posted information should show where the hospital is with regard to meeting the quality indicators and where it wants to be.

"Many studies show that posting the results is one of the most effective ways to drive improvement. Once the staff realize it is an issue, they can analyze where the problems are and bring all the departments involved together to strategize how to fix the problem," she says.

- **Issue reminder cards to physicians and nurses.**

Qualis prints out reminder cards for physicians and nurses about the importance of the quality indicators and the steps they should take.

The laminated cards fit easily in a pocket and outline the quality indicators with a description of why it's important to comply with them.

- **Issue physician report cards.**

Physicians respond well to hard-and-fast data, Scott points out.

"Physician report cards are an effective way to drive improvement. When you can show them their data and be able to back up the data, it's very effective," she says.

- **Celebrate success when you meet your goal.**

"When the staff have done something well and improved a process, you should celebrate it. This will let those involved know that their efforts are recognized and valued. It helps with sustaining the momentum in the improvement activities," Scott says. ■

New care management model cuts LOS, observation days

Clerical tasks eliminated for case managers and social workers

Redesigning the care management model and creating a resource center to free the clinical staff from clerical work has resulted in decreases in length of stay and helped drop denials for clinical reasons to zero at St. Vincent's Medical Center in Jacksonville, FL.

Overall average length of stay has dropped from 5.56 in fiscal 2002 to 5.0, following the first complete year of the program. Length of stay for fiscal 2001 was 5.35, indicating a rising trend before the program was instituted.

Length of stay for patients with less than a 15-day stay dropped from 4.4 days in fiscal 2002 to 3.9 days in fiscal 2003. Fiscal 2004 averaged 3.8 days.

The number of outliers — patients with complex conditions who stay 15 days or longer — has dropped from 1,495 in 2002 to 1,196 in fiscal 2003.

"The savings have been significant. Our new model increased the departmental FTEs [full-time employees] and operating expenses, but we have reduced lengths of stay and ensured that patients are placed in the right status and into the correct bed type. As a result, we no longer get denials for clinical reasons," says **Jamie Zachary**, LCSW, the hospital's director of care management.

Until 2002, the hospital had a traditional model of care management, with social workers handling discharge planning and patient education and utilization review nurses who handled chart review and calling in their reviews to the insurance company. The utilization management nurses had no patient interaction.

The hospital conducted a pilot project on three units in 2001 and rolled out the redesigned model hospitalwide in May 2002.

Under the new model, the social workers and care managers work as a team and are assigned by unit. The care managers see the patients on the floor, perform assessments, and work closely with the floor nurses to try to move the patient through the inpatient process in a timely manner.

They work with ancillary departments to move patients up on the schedule if discharge hinges on getting test results.

"The care managers can identify patients' discharge planning needs more quickly than the staff nurses and refer them to social work or the appropriate resource," Zachary notes.

Social workers handle complex discharge-planning needs, counseling and support, and end-of-life issues. They also coordinate nursing home placements.

A key component of the redesigned department was the creation of a resource center with staff who assumed clerical functions from the clinical staff, freeing up care managers and social workers to spend additional time with patients.

"One of the pitfalls of our pilot project was that we still had the nurses spending a lot of time on the phone with the insurance companies, and we still had the social workers making referrals to nursing homes. The positions in our resource center eliminate that nonproductive time the clinical staff was spending on clerical duties," she points out.

The resource center is staffed by three payer specialists who handle the telephone contacts with insurance companies and close the loop on obtaining authorizations, a placement specialist who handles referrals to nursing homes, a denials management specialist who oversees the appeal of denials, two staff assistants who handle clerical duties such as copying patient records and calling

referrals to home health companies, and a department secretary. **(For details on what these staff members do, see chart at right.)**

Pulling the clerical duties away from the care managers and social workers was one of the biggest factors in increasing efficiency, Zachary says.

"Anyone in the industry knows that calling an insurance company with a clinical review can take an hour, depending on the number of phone prompts and how often you're put on hold. In the traditional model, nurses are doing that, and it takes their time away from working with patients or addressing care coordination issues," she points out.

The care management staff like the new arrangement.

Judy Pullen, RN, care manager, who worked under both models, says, "Having the resource center take all that clerical work away gives me time to focus on the patients and their families. I love it because it benefits the patients, the physicians, and the hospital."

In the past, Pullen spent all her time doing utilization management.

"Case management is all about holistic care. When we came together as a care management department, we were able to interact with the patients and families and look at all the dynamics to make sure they are going to be able to go that next step when they go home and get well," she continues.

The care managers and social workers are paired and work effectively within the unit. Each has assigned space on the unit in which they work.

"They are ingrained to the life of the unit and see themselves as part of the unit," Pullen says.

The staff start their day in the care management office, where all clinical staff have desks, then move to the units for the bulk of the day.

"We've found it to be a positive arrangement to have an area where all the staff can start and end their day because they do a lot of interacting the first thing in the morning and toward the end of the day. They can bounce ideas off each other and help each other with the complicated cases. They are also a tremendous support for each other, offering assistance as needed," she says.

Since the new model was rolled out, the hospital has cross-trained the social workers and care managers to back up each other in some areas.

"The teams have worked well together, and they back each other up. If one team member

St. Vincent's Hospital Resource Center Positions

- ✔ **Payer specialists:**
  Prompt the care manager to complete an insurance review through a computerized task list. After the care manager has conducted a review for an insurance company, the information electronically comes to the payer specialist, who gets it to the insurance company and negotiates the authorization with the company. The payer specialist then works directly with the care manager to ensure another review is conducted before the patient's authorized stay expires. For instance, if the insurer approves two days, the payer specialist sets it up so that the care manager is notified to conduct another review within two days.
- ✔ **Placement specialist**:
  Makes all the referrals to nursing homes for all patients. The hospital places an average of 280 patients in nursing homes or rehabilitation facilities each month. In the past, the social workers would call the same nursing homes about different patients every day. Under the new arrangement, the placement specialist can call all the nursing homes, find out about available beds, and make more than one referral at a time. The placement specialist works directly with the social workers to anticipate the discharge day and prepare in advance so a nursing home bed will be available on the day of discharge. At first, the hospital required the placement specialist to have a bachelor's degree in social work. The requirements have changed, and the position has since been filled with someone with experience in office management at a large physician practice.
- ✔ **Denials management specialist.**
  This employee works closely with the payer specialists to help overturn any denials for payment. In many cases, she already has the documentation at hand and is able to get the payment approved by telephone, without having to file an appeal.
- ✔ **Staff assistants**:
  These two employees, who worked in other clerical jobs within the medical center, make all the referrals for home health and durable medical equipment, copy the charts for patients going to skilled nursing facilities, and make all the transportation arrangements for all patients. They fax any patient information that is needed for dialysis center referrals and disability applications.
- ✔ **Department secretary:**
  Handles all incoming calls, greets visitors, and provides secretarial support to the director and manager.

is busy and a referral comes in, the other team member can pick up and help out," Pullen adds.

The only exception is that the social workers don't do clinical review for insurance companies.

The interdisciplinary teams meet once or twice a week and go over the care of all the patients on the unit, Pullen adds. The teams include the care manager, social worker, patient care coordinator from the unit, pastoral care, a physical therapist, the nutritionist, and the pharmacist if needed.

As the care managers and social workers began working under the new model, the department found issues that were occurring frequently and were able to make process changes to eliminate denials.

Under the new model, the care management team worked to cut down on the number of observation days, resulting in a drop from 805 in July 2002 to 750 in October 2002 to 552 in January 2003 to 321 in April 2003.

"We felt that we had too many observation days. We were putting patients in observation when they came out of surgical procedures when they should have been moved into observation only if they met criteria," Zachary says.

For instance, the insurance companies were approving an inpatient stay for patients who had lumbar laminectomies but the physician was checking off the order for observation.

This resulted in a review of all standing orders for post-surgical and emergency department (ED) patients and eliminated standing orders for observation, instead giving physicians a choice of where to place the patients. The hospitals' post-anesthesia care unit nurses make sure the physicians issue orders for patients to be admitted or place in observation after surgical recovery.

Under the new model, the ED is staffed by care managers from 8 a.m. to midnight. Their goal is to identify whether patients need to be placed in a bed, whether they meet inpatient or observation criteria, and to make sure the patients get to the right level of care. For instance, if a physician writes an order for telemetry, the care manager makes sure the patient meets the requirements for a telemetry bed.

"There is a tremendous benefit to having a care manager in the emergency department making sure patients are in the right bed type and the right status," Zachary explains.

When the design was rolled out, the care managers and social workers initially were assigned to groups of physicians.

"Our intent was that they could work as a team with the physicians," she says.

By the end of the first week, the department realized that assigning care managers and social workers to physicians was not going to work in a 520-bed hospital with 22 different units.

"Not only were my staff running all over the hospital, but the staff on the units were complaining that they didn't have enough room for five or six members of the care management team to be on the unit at one time. We went back to the unit-based model because it works more efficiently for us," Zachary adds.

Looking at the whole picture

The hospital originally tried the physician-centric model of care to provide continuity in care if patients move from one unit to another during the hospital stay. However, at St. Vincent's, most of the patients who are moved go from critical care to a lower level of care.

"The care managers in critical care don't usually work directly with the patients because most of the patients are on a ventilator, so having the same person follow the patient is not necessarily an advantage.

"One of their goals is to identify patients who could move to a lower level of care or an alternative setting. We found that not assigning care managers by unit was a deterrent to what we are trying to accomplish," she says.

As a result of the redesigned model, the hospital's physicians are seeing case managers as a good resource, Pullen adds.

"Since we are looking at the whole picture and involved in managing the patients' care, we can bring things to their attention that they might not know about. They've become more confident in our abilities and skills," she explains.

In the spring of 2001, the hospital conducted a six-month pilot project on three units, pairing social workers and utilization review nurses to jointly coordinate patient care on the infectious disease unit, general medicine unit, and telemetry unit.

The hospital set and tracked indicators for each unit to measure the outcomes.

For instance, one of the infectious disease indicators was to move patients from IV antibiotics to oral antibiotics in a more timely manner.

"This would be better for the patient, and it would reduce length of stay and reduce our cost," Zachary says.

In the telemetry unit, one of the goals was

to move patients from telemetry as quickly as possible.

The care management teams met or exceeded all the indicators in all three units.

After six months, the care management department was able to demonstrate a significant cost savings generated by the pilot project and decrease in length of stay when it was an indicator for a particular population.

After the pilot, Zachary took a proposal to redesign the care management department to the senior leadership, showing how rolling out the new model throughout the hospital would affect the quality of care and utilization of resources.

"My proposal involved using the resources we had and adding some staff. I estimated it would take about 14 months to roll out. Senior leadership liked the model so much and were so impressed by the potential of cost savings that they wanted to roll it out before July 1, 2002, the beginning of our budget year," she says.

The medical center chose a consulting group to help roll out the new arrangement and worked with it to further develop the model. Working with the consulting firm, the department went live with the redesigned care management process in just four months.

The new system was rolled out in mid-May 2002, to give the department some time to work out the kinks before the new fiscal year began July 1.

Hiring people for the new positions was one of the most time-consuming and challenging parts of rolling out the new department, Zachary says.

"We established the job descriptions in the way we thought to be the most efficient and effective," she says.

The existing utilization management nurses had to apply for care management nurse positions because it was a new position.

"We looked for the best possible candidates for those positions. Some chose not to apply, some chose to be interviewed and were not selected. Some interviewed and were selected," she says.

The social workers' jobs were not new positions so the existing social workers stayed in those positions. All of the resource center positions were new.

"While we were posting the positions and interviewing people, we developed the training program and content," Zachary says.

The three-day training program was for all staff, but at times, the staff were broken into small groups. For instance, only the social workers and placement specialists participated in the nursing home placement component.

Several departments worked with the care management department on education and training, including the managed care, patient accounting, patient access services, information services, nursing, and other ancillary departments.

Following implementation of the new model, feedback from these departments was used to implement other changes or processes.

For example, now representatives from the care management staff meet monthly with the hospital's biggest payers and quarterly with other payers, discussing issues related to utilization, preauthorization, insurance verification, and payment.

"It's helped to establish a really good relationship with the payers so we can handle any issues concurrently. We have also established teams to continually evaluate our success dealing with issues such as status change and denials," she says.

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AMBULATORY CARE
QUARTERLY

ED sees 50% reduction in time from triage to ED bed

Define problems and then benchmark

(Editor's note: In this first part of a two-part series on benchmarking, we tell about two hospitals that achieved dramatic reductions in length of stay (LOS). Next month, we discuss how to speed up admissions by addressing virtual capacity issues with the entire hospital.)

Would you like to see a 50% reduction in time from triage to emergency department (ED) bed? How about significant improvement in LOS for admitted patients and treated and released patients? These are some of the concrete benefits that the EDs at Lehigh Valley Hospital in Allentown, PA, and Saint Rita's Medical Center in Lima, OH, have achieved with the targeted application of data uncovered through benchmarking.

"What we have done here is benchmark to *define* problems," says **Richard MacKenzie**, MD, FACEP, vice chairman of the department of emergency medicine at Lehigh Valley. Keeping the problem in the forefront has been one major lesson of his benchmarking experiences, he says. "Also, you have to be able to monitor the effect [you have had] on the problem," he adds.

Saint Rita's modeled the success of a similar facility by copying a single practice it learned of through a news story and reduced overall LOS from 190 minutes to 160.

The key issues at Lehigh Valley were identified by a collaborative management team of nurses and physicians that had been leading a series of subproject teams to focus on prolonged ED LOS.

"The subprojects we identified were bedside registration and rapid triage," MacKenzie notes.

Using national data provided by Karpiel Consulting Group in Long Beach, CA; the Institute for Healthcare Improvement in Boston; and Press Ganey Associates in South Bend, IN, the team found they took probably 10-20 minutes longer than most of their benchmark facilities to place patients into an ED bed.

"We were still doing front registration and had a very sequential process of triage, then registration, then to the ED," MacKenzie explains.

Now, the process is parallel, he says. "We do a short triage, get a bed available, the patient goes back to bed, and we do a short registration there," MacKenzie adds.

If there aren't beds available, patients receive a short triage. Subsequently, they go back to the waiting room. When a triage nurse is free, they return to triage for complete assessment and possible labs, and then return to the waiting room until a bed becomes available. The short triage is done in the presence of a registration clerk, who takes the patient's name, Social Security number, and perhaps, date of birth. The triage, which takes about five minutes, includes the Emergency Severity Index (ESI) and vital signs, if there's a high-risk complaint.

"We've seen about a 50% reduction in time from triage to ED bed: from 37.8 minutes monthly average to 16.8 minutes monthly average," MacKenzie reports.

As part of Catholic Health Partners, Saint Rita's benchmarks against corporate data, as well as using Press Ganey and the Emergency Department Benchmarking Alliance, a nationwide group of emergency physicians and nurses. Lehigh Valley also participates in this alliance.

However, one of its most memorable initiatives came as the result of a news report about a 30-minute ED pledge made by Oakwood Hospital and Medical Center in Dearborn, MI, recalls **William E. Tucker**, MD, FACEP, Saint Rita's medical director of emergency services.

"They promised their patients they'd be seen within 30 minutes or they would be given a present," he says. "We benchmarked how they did that."

During the same time period, the staff at Saint Rita's had conducted customer surveys and found that aside from receiving good care, what patients

cared about most was how much time they spent in the ED. These survey results reinforced the need for the project.

"What we copied was moving our treatment rooms closer to the front door, keeping our waiting room empty, and getting patients back to the room as quickly as possible," Tucker notes. The Oakwood model was adapted to meet the specific needs of Saint Rita's. "For example, we did not have the ability to have a physician at the front door, like Oakwood did, so we put a PA [physician assistant] there," he says.

In the past, patients were seen by a nurse in triage then assigned to express care, pediatrics care, or acute care. Next, they were put in a room and seen by a doctor before anything was done. Now, the PA is certified by hospital bylaws as a medical screening examiner with the power to order diagnostics.

"We put in wireless phones, which allowed the PA to have private conversations with docs about patients," Tucker explains. "The physicians are able to give verbal orders to start therapeutics."

The initiative has been extremely successful and led to a significant decrease in left without being seen patients. "We have 0.75% of patients leaving without treatment, which is much lower than any national average," which is usually 2% to 3%, Tucker says.

It also has resulted in a decrease in LOS: for treated and released patients, from 169 minutes to 143 minutes; for admitted patients, from 341 minutes to 284 minutes; and for overall LOS, from 190 minutes to 150 minutes, he adds.

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- ***Catholic Healthcare Partners**, 615 Elsinore Place, Cincinnati, OH 45202. Phone: (513) 639-2800. Fax: (513) 639-2700. Web: www.healthpartners.org.*
- ***Institute for Healthcare Improvement**, 375 Longwood Ave., Fourth Floor, Boston, MA 02215. Phone: (617) 754-4800. Fax: (617) 754-4848. Web: www.ihi.org.*
- ***Karpiel Consulting Group**, 6475 Pacific Coast Highway, Suite 402, Long Beach, CA 90803. Phone: (562) 597-1108. Fax: (562) 597-7448. E-mail: marty karpiel@karpiel.net.*
- ***Press Ganey Associates**, 404 Columbia Place, South Bend, IN 46601. Phone: (800) 232-8032. Fax: (574) 232-3485. Web: www.pressganey.com.]* ■

CE *questions*

This concludes our CE semester. Please fill out the enclosed CE evaluation form and return in the envelope provided.

22. How many patients were at Sacred Heart Hospital in Pensacola when Hurricane Ivan hit?
    A. 150
    B. 200
    C. 360
    D. 75

23. The goal at Presbyterian Hospital of Dallas is to complete an analysis of denials and submit an appeal in what length of time?
    A. 30 days
    B. 15 days
    C. 60 days
    D. 45 days

24. According to Carolyn Scott of VHA, Inc., CMS plans to expand the 10 quality measures in its public reporting sector to how many measures in 2005?
    A. 15 to 20
    B. 17 to 22
    C. 25
    D. 12 to 15

25. Some of the quality improvement measures suggested by quality experts include:
    A. chart stickers and standardized order sets
    B. physician report cards and posting results on the unit
    C. reminder cards for nurses and doctors and celebration of success
    D. all of the above

26. In the first year of the new care management system at St. Vincent's Hospital in Jacksonville, FL, overall length of stay decreased by how much?
    A. one day
    B. half a day
    C. no change
    D. 25 days

Answer key: 22. C; 23. A; 24. B; 25. D; 26. B

(Continued from page 181)

for clinical excellence with VHA Inc., an Irving, TX-based health care cooperative.

In 2005, the Centers for Medicare & Medicaid Services (CMS) plans to expand the 10 quality indicator measures in its public reporting sector to between 17 and 22 measures, she points out.

"The burden is not going to lessen. It's going to be greater. The quicker we can get a handle on improving quality indicators now, the more prepared we'll be for additional measures," Scott adds.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) already provides a financial incentive for prospective payment system hospitals to voluntarily report quality of care information. Those who submit data will be eligible to receive full Medicare payment for health care services under MMA. Those who did not submit data will receive a 0.4% reduction in annual Medicare payments.

"The trend in public reporting is well on its way with JCAHO [the Joint Commission on Accreditation of Healthcare Organizations] publicly reporting some quality indicators for hospitals. We're only going to see more of that happening as we go along," adds **Earl Kurashige**, RN, project manager for Qualis Health, a nonprofit health care quality improvement company based in Seattle.

Beginning in 2005, hospital quality data will be available on a consumer web page, Hospital Compare, which is part of www.medicare.gov.

Quality improvement means involving all the people in the health care delivery system, Kurashige points out. "It's not just doctors and not just hospitals. We can't just point the finger at one group and say you need to do better. It's a team effort," he says.

The team approach to improving quality is a paradigm shift for health care providers, notes Kurashige. "Everyone working together to improve health care of the individual can have a big influence on the care and quality," he says.

Scott and Kurashige work with hospitals on quality improvement projects, particularly those relating to the CMS and JCAHO quality indicators, where most hospitals focus because they are the center of attention in health care.

They agreed to share strategies with *Hospital Case Management*, pointing out the techniques will work for any quality improvement project.

The first step in driving improvement is starting at the top, Scott asserts.

"If you really want to drive improvement or change in the organization, senior management must be involved and actively engaged. The senior leadership needs to be engaged and make others realize that this is a priority," she says.

Involve people on the quality improvement task force who work directly with the patients whose care you want to improve.

For instance, if you are dealing with cardiac issues, involve the head of cardiac services, the head of the emergency department, the director of the cardiac catheterization lab, and a leader from the intensive care unit.

"It must be a collaborative effort. Member of the task force learn from each other as well as from the materials you provide," Scott says.

Along with the administration's backing, hospital staff need to have one of their peers championing the cause, she adds.

Don't choose a champion who is new to the team or someone who wants to work his or her way to the top, Scott suggests. Find someone that everyone on the team looks up to and respects. Anytime you implement something new, it's important to involve the physician champion in the planning process, she adds.

"To get adequate physician buy in, they need to see how what is being done will be of benefit to them. They will resist if they think it's more work or if their autonomy is being taken away," Scott explains. Setting goals and assigning responsibility for meeting quality measures is important. "Things fall through the cracks if there is no specific responsibility," she says.

Case managers should play a very large part in assuring that the quality of care continues to improve, Kurashige notes. "In many cases, we want to be sure that those patients who are in the hospital have sufficient information on how to take care of themselves when they are discharged, especially if they go home and have home health agencies provide care for them. Case managers certainly do the brunt of that work in handling discharge management," he says.

Case managers can be invaluable when it comes to making sure that the quality indicators are met, Scott adds.

"By reviewing the charts and reminding staff about the requirements of some measures, they can help drive improvement. Sometimes the staff are just too busy to remember everything they need to do," she says.

Case managers have been the key in process improvement in many hospitals, Scott says. "For the cardiac-related core measures, a big issue for

case managers is identifying which patients are heart failure patients and which are AMI [acute myocardial infarction] patients. Heart failure patients can be anywhere throughout the hospital after being admitted for many different reasons," she explains.

Early identification of these patients and early engagement of the case managers is vital so case managers can flag the chart, conduct a concurrent review, and remind staff if any indicators are missed. "If case managers have to do retrospective review and something didn't get documented, it shows up in the statistics as a missed opportunity. Case managers need to be able to review the charts concurrently when the patient is in-house," she says.

In some hospitals, the pharmacist assigned to the floor assumes the role of case manager for drug-related issues, such as aspirin, ACE inhibitors, or beta-blockers.

Smoking cessation counseling is another area where case managers are invaluable in tracking that the counseling has been done, Scott says.

The most successful groups with smoking cessation indicators are groups that have an automated admissions process during which a patient is asked if he or she has used tobacco within the last year, she says. If the answer is yes, the patient automatically is referred to the people within the hospital who do the counseling, such as respiratory therapy or cardiac rehabilitation staff.

Scott works with the CEO work groups for clinical excellence, bringing the CEOs of its member hospitals together and working with them on areas where they want to drive improvement. After receiving input from the CEOs, she convenes the task forces from participating organizations to address the identified areas of need.

"Because of public reporting, coupled with pay for performance, many of them select to work on AMI, heart failure, community acquired pneumonia, and surgical infection prevention," she says.

VHA sets goals for compliance on each performance measure. Hospitals that perform at 90% or more on every single measure are called green light hospitals. Those performing at 80% to 90% are yellow light hospitals. Any performance less than 80% is considered to be red light.

"That is how we set goals and develop at thresholds," Scott notes.

The hospitals that participate in VHA's quality initiatives enter their data every quarter using a web-based tool.

"Within our work groups, the data are not blind. It's no secret who is performing well and who is struggling. Those who need improvement on a certain measure can ask their counterparts at hospitals doing well on the measure for extra help," she says.

Qualis compiles hospital data from JCAHO, CMS, and other organizations and distributes them to participating hospitals, showing them how they compare to state, regional, and national data. The company has just finished its first round of meetings for each of the five regions in the state of Washington. The topics covered at regional meetings are suggested by participating hospitals and are specific to the needs of that region.

In some cases, the hospitals are asked to present programs on quality as well.

"We ask the hosting hospital to showcase their quality program and share what they are doing to help raise the bar for everyone else. The goal is not to create an atmosphere of competition. The intent is to raise the bar for quality, and we're emphasizing a cooperative endeavor to achieve that," Kurashige says.

If hospitals discover that their rates are low in one of the quality indicators, Qualis suggests simple methods they can use to help improve their rates, especially for national reporting of data, he says. "We do this so others can gather the information that is presented and start one of their own programs or enhance a program they already have," Kurashige explains.

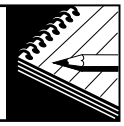
The regional meetings have been very popular with participating hospitals, he says.

"We ask them what quality issues they are interested in hearing about and what kind of speakers, data, and tools they would like to have to help improve quality. When we follow up with the hospitals, they express appreciation to have the opportunity to share information that can help them improve quality," he adds. ■

COMING IN FUTURE MONTHS

- Tips on handling referrals for hard-to-place patients
- Best practices for case managing patients without insurance
- Finding the best technology for your purposes
- How to determine which model works best for you

GUEST COLUMN



How to unjam your discharge bottlenecks

Failing to do so means lost revenue

By **Patrice Spath**, RHIT
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Are admitted patients being held for a long time in the emergency department while they wait for an inpatient bed to become available? Do patients in specialty care units stay longer than necessary because there is no general unit bed for them to be transferred to?

When ambulatory surgery patients need to stay overnight, are they kept in a hallway or a special holding area until an inpatient bed is freed up? If you answered yes to any of these questions, your organization has a serious patient flow traffic jam. Inability to bring in new admissions or transfer inpatients to the appropriate level of care means lost revenue for your organization.

In addition, patient satisfaction is adversely affected by long waits for inpatient beds. Often, this problem is blamed on a lack of bed capacity when in fact the source of the problem is inefficient patient flow. The beds are there; the hospital just doesn't turn them over effectively.

An old idea that is regaining popularity is the discharge lounge. Once considered merely a convenience for patients who don't have a ride home immediately upon discharge, the discharge lounge has become an important bed control mechanism.

The basic idea is to free up hospital beds for patients needing acute care or active clinical observation. Patients who are ready to leave the hospital can go to the discharge lounge while waiting for their ride home. These can be discharged inpatients, ambulatory care patients, or people who have been discharged to home from the emergency department.

A clinician, often a registered nurse or licensed practical nurse, and support staff or volunteers staff the lounge. These people can assist discharged patients by telephoning family members, arranging for physician follow-up appointments, helping patients plan for basic home care needs, and obtaining prescribed medications from the outpatient pharmacy. If there still are some unresolved financial issues, counselors can discuss paperwork or insurance information with patients in the discharge lounge. And of course, light meals or snacks are provided.

If your hospital does not enforce a defined discharge time, this issue must be revisited before creating a discharge lounge. If patients are discharged at any time throughout the day, the hospital's ability to manage patient flow is greatly hampered. Are patients often allowed to stay for lunch or dinner, even though they no longer require acute care services?

This may improve patient and family satisfaction with the discharge process; however, those patients in holding areas waiting for inpatient beds likely will be very dissatisfied if admission is not timely. Physicians must be encouraged to discharge patients in the a.m. so hospital beds can be freed up for new admissions. Show physicians the big picture and let them see how they contribute to success or failure. Key statistics on discharges and admissions will let doctors understand how missing an 11 a.m. discharge can impact overall patient flow.

It should not be acceptable for physicians to discharge patients during evening rounds when a discharge order would have been just as appropriate in the a.m. Physicians should receive regular feedback about their discharge practices and the effect of these practices on patient flow, e.g., number of patients discharged after 5 p.m. vs. number of patients in holding areas waiting for admission to those beds. Physicians who are repeat offenders should be referred to the department chair for action.

Patients and families should be notified of the hospital's discharge time and encouraged by the physicians, nurses, and case managers to leave by this time when they have been discharged. Case managers should reinforce the discharge time by inquiring about rides home, etc., early in the hospitalization so special arrangements can be made if necessary.

If the hospital has a defined discharge time, the environment may be right to create a discharge lounge. Patients who are ready for discharge but for some reason cannot leave the hospital right away can wait comfortably in the lounge until their departure. If possible, locate the lounge in close proximity to admitting, the emergency department, or an appropriate exit area.

Ideally, patients can look out the window and

watch for their rides. The discharge lounge should feature reclining chairs, televisions, private bathrooms, and other amenities.

The aim should be to develop a "home from home" atmosphere on the unit. It should be open during the day and close sometime in the evening. Staff the area with appropriate clinicians (e.g., RNs or LPNs) in addition to support staff. Otherwise, emergency department staff or inpatient bedside nurses may resist the lounge idea — afraid that patients are being moved to an unsafe, unmonitored area.

Waiting for physicians and nurses to use the discharge lounge can lead to no use. Have the clinician assigned to the discharge lounge, as well as case managers, make rounds to identify patients ready for discharge who are candidates for the lounge. Staffing the lounge with volunteers who simply wait for discharged patients to be escorted in will result in minimal usage. Case managers should reinforce the purpose of the discharge lounge and encourage patients to take advantage of this service if it appears that departure may be delayed.

Nursing staff also must be involved in voicing this encouragement. New unit admissions can mean additional work for the nursing staff, so it is understandable why they may be reluctant to persuade patients to vacate beds as soon as possible. The inpatient units often are full, so moving out healthy patients who require relatively little work frees up beds that are immediately going to be filled with still-sick, high-maintenance patients.

So in the current environment, there actually is an incentive for caregivers to slow the discharge process. That's why support of the discharge lounge by senior leaders as well as charge nurses and supervisors is very important.

At first, there may be some reluctance by physicians or staff to release patients to the lounge in case an untoward incident occurs. To overcome this resistance, undertake an awareness-raising program of education to gain support of the medical staff and other caregivers.

Once the discharge lounge is equipped and staffed, make it available as a pilot project. Gather patient satisfaction data from all patients who used the lounge to determine success from the patients' perspective. Also gather information on how many inpatient and emergency beds were freed up by having discharged patients use the lounge. Success of the initiative can be measured by evaluating issues such as:

- length of stay in holding beds for patients awaiting admission;
- frequency of the hospital being on divert status;
- percent of emergency patients waiting more than four hours from decision to admit to being transferred into an inpatient bed;
- percent of ICU/CCU patient transfers to general unit beds that occur within four hours of transfer order.

The measurement data, if they support the value of the discharge lounge, can help build momentum for increased use of the lounge. Eventually, the discharge lounge nurses will be able to free up even more valuable resources by providing a safe and patient-friendly atmosphere for people waiting to leave the hospital. ■

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. ■

Hospital Case Management
2004 Index