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IN THIS ISSUE

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Medical management program offers advice by secured e-mail, telephone

Aim is to help members adopt a healthier lifestyle

A new, innovative medical management program by Blue Cross and Blue Shield of Illinois helps members take charge of their own health by providing interactive tools and information about health conditions, including opportunities to e-mail a nurse care advisor, personal trainer, registered dietitian, or health coach and get an answer back within one business day.

Blue Care Connection, available to all members, allows members to create their own Personal Health Manager, an interactive, web-based resource that gives them information they can use to make informed health care decisions. The system gives them the opportunity to access on-line health materials and receive targeted wellness information and reminders for preventive care and condition-specific milestones so they can better manage their health.

"The members have access to a system of electronic messaging that is totally protected. Only the member can log on and give their nurse care advisor access to their personal health manager," reports **Colette B. Burke**, RN, executive director for medical management at the Chicago-based insurer.

If employers choose a more comprehensive package called Blue Care Advisor for their employees, members have access to the Personal Health Manager as well as other interactive features, such as Ask a Nurse, which allows them to communicate with a nurse care advisor via secured e-mail or telephone and Ask a Trainer, which allows members to ask a physical trainer on-line questions about weight management and fitness activities. The member also can send secured messages to a registered dietitian and health coach. All responses are received within one business day.

Later this year, Blue Cross and Blue Shield of Illinois will extend the Personal Health Manager messages and reminders to people who don't have a computer or don't want to use the computer, via automated outbound calling to remind members of gaps in care.

"We want to reach the member and deliver the same services and information via telephone for people who are not comfortable with the computer. We still use the old-fashioned way of delivering information. If someone requests it, we can mail him or her specific written information about his or her condition," she says.

The members will have a toll-free number to dial at their convenience.

Participation in Blue Care Connection is strictly voluntary. The program has two goals: To educate the members so they can do the right things and enjoy a better quality of life and to stabilize their conditions and get them self-invested in wellness, with the ultimate goal of reducing emergency department and hospital visits.

Members start their interactive health management by taking a 15-minute health risk assessment. The assessment uses branching logic to generate additional questions for certain conditions. For instance, if the member has asthma, the assessment asks questions about taking a rescue medicine, knowing asthma triggers, having a written action plan, and using a peak flow meter.

The web site allows them to set up a personal health record that can be shared with designated people, including family members and physicians anytime and anywhere Internet access is available.

The company's predictive modeling system allows it to examine claims data to identify the population that needs help and to tailor the Personal Health Manager to their needs. For instance, if an insulin-dependent diabetic logs onto his or her Personal Health Manager, he or she has immediate access to information on diabetes. The e-mail messaging system reminds the member when it's time to get an eye exam or foot exam or other recommended services.

"What we are attempting to tackle is behavior changes. It's not so much managing the condition or disease but giving the members the information they need to better manage their health," Burke says.

The system concentrates on educating members with chronic diseases about the importance of managing their conditions, how to recognize symptoms, and know what National Standards of Care are for their specific condition; in other words, what they should do to stay healthy. All information is written at an eighth-grade level with lots of graphics.

"We tell them that although they have diabetes, they can live a full life if they follow a certain lifestyle that includes exercise, a proper diet, and the National Standards of Care for Diabetes," she says.

The health plan can send members as many as five daily health updates to their Personal Health Manager web site. For instance, if there is new information about a drug a member is taking, the health plan forwards it to him or her and urges the member to discuss it with his or her physician.

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Editorial Questions

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"We built a technology system to reach the right people who need our help and to give them the tools they need to better manage their health," Burke says.

Unlike many medical programs, Blue Care Connection doesn't ignore members who do not have chronic diseases.

"Even if the member is young and healthy, we send out reminders for preventative procedures, such as Pap smears, PSA test, colorectal screening, etc., telling them we want them to stay healthy. We offer total health management — something for everybody whether they're young and healthy or living with a chronic condition," she says.

The web site encourages members to log on to online libraries such as the Annotated Dissection of Anatomy of Medicine (ADAM), which is the medical encyclopedia for the National Library of Medicine.

The health plan started rolling out Blue Care Connection and Blue Care Advisor in January.

"Employers love it. They like the idea of connecting their employees one-on-one with a nurse who can give them support and the education they need specific to the condition they're living with," she says.

Members who are eligible for Blue Care Advisor may e-mail or call a nurse care advisor, who is a registered nurse trained in specific condition management, wellness education, and how to work with members to embrace lifestyle changes.

They receive additional training on communication skills that help them get the members to engage in healthy behavior.

"Their training gives them the skills to sell the idea that it will be worth it to the member and that they will feel better if they give up cigarettes, start eating right, start walking every day, or whatever they need to do to have a better quality of life," Burke says.

There is a dedicated team for this web-based program. The nurse care advisor educates members on the importance of medication compliance, regular doctor visits, following National Standards of Care for their specific condition, eating right, and getting fit. The health plan identifies the members who need outreach by the nurse care advisor from both its predictive modeling software, which utilizes claims information, and through the members' completed health risk assessment.

"The outreach part is very important to us. We have a Blue Cross member and a Blue Cross nurse working together to improve the member's health and quality of life," she says.

With these members, the nurse care advisors make outreach calls and work directly with the member to set goals and manage their condition.

Members are encouraged to call or e-mail their nurse care advisor whenever they have questions.

The nurse care advisor works with the member to help set goals and achieve them.

"We encourage members to plan ahead and not to walk into a situation where they'll go off their diet, for instance, and then decide it's no use getting back on track," she says.

Members work with the same nurse care advisor until they can verbalize that they understand the importance of their condition-specific milestones.

The member will continue to receive reminders via his or her Personal Health Manager.

"Now the members know they have a Blue Cross nurse they can talk to who can help them prepare for their next doctor's visit and be there for them after the visit if there is something they don't understand. The nurse gives them the information and help they need to get on with their life," she says.

The interactive system allows a Blue Cross nurse care advisor to bond with members who choose to be a part of the program and to support the members in a very personal way, Burke says.

"In the past, we mailed out brochures and magazines and newsletters, but it's hard to know how many people read them and how meaningful they were," she adds.

In the future, the Personal Health Manager will include information for all new mothers, listing milestones for newborns, including vaccination information, growth and development information, and to create an awareness of when their baby's condition warrants a call to the doctor.

"We want our members to be savvy consumers and educated about the health and well-being of their little ones," Burke says.

"The parent will have a personal record for each child as they go to the pediatrician. If they are on vacation and the child gets sick, she'll have all the information she needs available on the Internet," she adds. That's what it's all about . . . Giving the right information to the right person at the right time so they can take charge of their health." ■

Predictive modeling helps identify CM candidates

Drill down to find those who will benefit most

Predictive modeling is an invaluable tool in early identification of people who can benefit from case management, but using the score alone doesn't go far enough, says **Kay Sherwin**, RN, CCM, director of client services for Integrated Healthcare Information Services (IHCIS), a Waltham, MA-based predictive modeling and information solutions firm.

"Predictive modeling is a very effective tool that can be used with other tools to identify potential case management clients, but it is not the be-all, end-all by itself," she adds.

The risk score shows how likely members are to need care or to utilize health care services, but to be truly effective, you need to look at the clinical details to see what is driving the risk, she adds.

For instance, if a patient has cancer, diabetes, and depression, knowing that diabetes is driving 60% of his risk may help you decide to refer him to a diabetes disease management program, Sherwin says.

Predictive modeling data can help you identify gaps in care, such as which diabetics are not getting their A_{1c} tests or which women haven't been screened for breast cancer. These gaps in care, or care opportunities, are more for identifying members for disease management or wellness activities, Sherwin adds.

"We know that around 1% of any given population will need case management services. But which 1% is the right group to manage?" she says.

Using predictive modeling only to identify members who are at highest risk will identify a lot of members who already are in care management.

Depending on how often you run the data, it could identify members who already have died of the disease or those who are following their treatment plan, and case management would have limited impact.

"The data also can give false negatives and false positives. Just getting the members who are at risk for health care events isn't going far enough," Sherwin explains.

Your predictive modeling tool may identify members who have a high risk for utilization of services but are managing their health and navigating the system very well on their own. These members don't need case management intervention.

"You want to find those members who have difficulty in managing the system or who have problems making decisions about their own health. They are not identified from predictive modeling but from a case management assessment," Sherwin says.

The ideal situation is to use risk modeling in combination with other tools and attributes to identify the members you want to reach, she adds.

For instance, by bringing in information from your organization's health risk assessment into the predictive modeling tool, you can use specific responses to add additional criteria as a filter that will help identify specific members, Sherwin says.

For instance, the health risk assessment could look at potential obstacles to compliance, such as whether there is a reliable caregiver at home.

Considering a member's response to rating his or her health status today in comparison to last year may help identify members more likely to benefit from case management, she adds.

Become familiar with member population

"Every organization I've worked with and every group of case managers has a different idea of where to find the sweet spot, those members are most appropriate to assess for case management. To be effective, you need to explore multiple ways to filter the information from your predictive modeling, such as looking at comorbidities in conjunction with high pharmacy utilization, abnormal test results, or any combination of factors," she says.

Sherwin encourages case managers to use their risk-modeling data to become intimately familiar with all the attributes of their health plan's member population.

"My advice is to play with the data. Pull up different criteria, and see what you yield," she adds.

For instance, you may want to target frequent fliers in the ED, regardless of diagnosis; members who are receiving more than three home care services; anyone with multiple chronic conditions; or members with postoperative infections.

"You're limited only by your imagination in determining where you can look to find the

opportunities to have an impact," Sherwin adds.

No matter how good a predictive modeling system is, it's still based on historical claims data, she cautions.

"There are so many pieces of information about a human that can't be quantified from claims information alone," Sherwin says.

Look for numbers in terms of diseases, utilization, providers, complications, or gaps in care to identify opportunities, she says.

Look at whether the member needs intensive case management or episodic case management.

It's not enough just to get risk assessment information. You need to drill down and find the opportunities for intervention and where you can deliver actions, she says.

For instance, you might look at the ICD-9 codes on claims to determine people with asthma with multiple prescriptions for rescue medicine, a sign that they aren't managing their asthma well.

Or, if you're examining data on cancer patients, look for patients who have advanced markers, who have a port for chemotherapy, or who show excessive use of pain medications and antidepressants.

Creating a case definition

"A predictive modeling tool is simply that. It's a tool, and the value you get depends on how much you drill down and identify members where you can take action and make a difference," she says.

Sherwin recommends creating a case definition to define the people you want to consider for case management.

Here is an example: All members who have diabetes, live in a particular region, and belong to a particular network product or employee group. The members have a 50% probability of an inpatient admission, have a relative risk score of greater than 10, and are currently not in case management or disease management. They have diabetic peripheral vascular disease, have not had a hemoglobin A_{1c} in the past 12 months, and are being treated by Dr. X, whom you have determined is not your most effective provider.

By using this definition, you can identify diabetics with significant risk who are not currently in a program, who already have diabetic complications, and who are not being monitored appropriately, she adds.

"Case management is very appropriate for people who have a combination of problems, including multiple psychosocial issues. Case managers can help these patients get the right care at the right time by the right clinicians at the right site but must start by identifying the members who can benefit most from case management," she says.

In the past, hospitalizations and illnesses have been the primary triggers for identifying members for case management. These are reactive and may be too late for effective interventions, she says.

"When I started as a case manager 15 years ago, the only referral system we had was 'patient who had been admitted to the hospital.' We had no history or demographics to work with. Now, we have a lot more data to help us identify people we can assist," she says.

In her early days as a case manager, Sherwin took a proactive approach to care, making outreach telephone calls to her clients.

"This is a very resource-intensive way to manage your members with the challenge of documenting the return on investment, and the approach has faltered in recent years," she says.

However, by using predictive modeling and other tools to identify the members who will benefit most from interventions, case managers use their resources where they will make the most difference.

"With the advent of predictive modeling and the ability to identify opportunities to improve patient care, I see a paradigm shift back to proactive case management," Sherwin adds.

When you identify members with the potential for case management, an outreach telephone call is the most effective method of conducting a health assessment, she says.

Today's challenge is that many nurse case managers haven't done much proactive care and they're not accustomed to making cold calls to members who may or may not be feeling sick at the moment.

Remember other tools

"Because of this, a lot of organizations are engaging their case managers in additional training, including motivational interviewing," Sherwin says.

Don't let predictive modeling take the place of concurrent review to identify members who could benefit from case management, she cautions.

"Predictive modeling and evidence-based

medicine are wonderful tools, but they won't identify members who will have a spinal cord injury, or a be high-risk newborn, or become a newly diagnosed diabetic," Sherwin says.

[Kay Sherwin, RN, CCM, is director of client services at Integrated Healthcare Information Services in Waltham, MA, which offers a predictive modeling system called Impact Pro. Web site: www.ihcis.com. Phone: (781) 895-9950.] ■

Take lead in filling your patients' 'perception gap'

Low health literacy affects many people

By **Mindy Owen**, RN, CRRN, CCM
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A perception gap often exists today between what health care providers say, prescribe, and advise, and what patients actually understand and carry out in their self-care. Many factors can influence this gap, including a lack of language comprehension. Yet, even when a patient is well educated, highly conversant, and appears to understand what the health care provider is saying, a perception gap can result.

Adding to the perception gap is greater fragmentation in care delivery and a lack of coordinated communication. This reflects the rise in complex cases as an increasing number of patients deal with catastrophic and chronic diseases. At the same time, however, they are receiving less acute care than they have in the past, with the average hospital stay down to 4.8 days.

In addition, patients are being seen by multiple health care providers with various specialties, which add to the fragmentation and many times lead to a communication breakdown.

Although it has been a goal of case management to help counter that fragmentation and bridge the perception gap, I do not believe we have achieved that yet.

For one thing, it is difficult for case managers to establish a rapport with a patient and his/her family, to provide education, and effectively communicate during a short hospital stay, when both the patient and family are feeling a heightened amount of stress.

In addition, a patient also may be working with more than one case manager; for example, an acute care case manager at the hospital, an insurance company case manager, and even a case manager who works in the home health arena. The result is an imperfect communication structure due to the number of health care practitioners, with more than one case manager trying to coordinate care and facilitate the exchange of information.

While communication problems and perception gaps are easier to identify when general literacy (reading, language, and overall comprehension) is an issue, the problem becomes masked when a patient is highly literate, but his or her health literacy is impaired.

Health literacy includes understanding a chronic illness and how it affects a person's life, plus treatment and self-care requirements. The risk with highly literate patients with low health literacy is that although they appear to understand, they may not follow through with treatment or they may not be astute about watching for signs and symptoms.

In fact, a highly literate/low health literacy patient may be the most risky situation because it is easy to assume that the person has comprehended instructions for medication, self-care, diet restrictions, and so forth. However, there may be gaps in that patient's perception due to what he or she heard (vs. what was actually said), and even judgments and opinions about taking medication — from whether it really needs to be taken to taking it more/less frequently than prescribed. Stress, anxiety and other emotional causes also can impact comprehension and widen the perception gap.

The perception gap is particularly problematic with medication, given the statistics on prescriptions: One-third of the prescriptions written are not filled by the patient, and of the remaining two-thirds, half are taken inappropriately or not at all. When a patient does not fully or adequately understand treatment, he or she may arbitrarily stop taking a medication, believing that it's "not doing anything; I don't feel any different" or taking it more/less frequently than prescribed. This highlights the need to address the perception gap as part of an overall drive to improve patient safety, whether in an acute-care setting, as outpatients, or administering self-care under a doctor's advisement.

For the case manager, the first responsibility is

to recognize that a perception gap may exist with every patient, including those who appear highly literate and capable of comprehending information and instructions given by a health care provider.

The next step is to assess the patient's ability to communicate with health care providers. In other words, does the patient exhibit sufficient literacy and health literacy to comprehend the practitioners' instructions? Does the patient comprehend his or her disease state and the recommended interventions? Are there language or cultural issues?

As an example, a diabetic patient I worked with did not follow through with self-administering his insulin shots because he expected his wife to do this for him. Until this factor became known, he was not receiving the prescribed dosage in a timely manner.

Fortunately, there are tools for case managers to assess patients and their level of communication and interaction with health care practitioners. These tools, which mostly track medication adherence, also provide case managers with the means to track patients using specific data measures. By utilizing these tools, case managers can gauge improvements in patient adherence, which also reflects their level of communication with providers.

In every setting and practice venue, and in specialties from pediatrics to geriatrics, case managers can help bridge the perception gap that affects patients and impedes the quality of the care they receive.

With more fragmentation among health care providers, shorter hospital stays, and an increase in the number and variety of care providers whom a patient may see, case managers fill a vital role. Case managers can assess patients' ability to comprehend what health care providers are telling them, and act as a conduit of information about a particular disease or health state, care, and treatment.

The first step to closing the perception gap is to recognize that it exists and then to implement a specific plan aimed at identifying patients' communication needs and providing the education and support they require.

(Mindy Owen, RN, CRRN, CCM, is principal of Phoenix HealthCare Assoc. LLC, a Coral Springs, FL-based consulting firm specializing in case management, disease management, and managed care development and education.) ■

Clinical redesign cuts LOS, reduces denials

Model integrates case management, social work

A clinical redesign project partnering social work and case management has resulted in a 15% drop in length of stay and a 66% reduction in denials during a period when the average number of cases increased by 24% at Children's National Medical Center in Washington, DC.

"Our denial rate now in terms of total patient days is very low. It's 1.5%. We have reduced our denials because, with our redesigned model and intense focus on moving patients through the plan of care, we have been able to reduce medical unnecessary days," says **Mary Daymont**, RN, MSN, CPUR, manager of case management.

New department created

The redesign created the clinical resource management department, combining the previously fragmented utilization management, case management, and social work functions.

Before the redesign, the case managers were under the performance improvement department, utilization was part of medical records, and social workers were in the department of family services.

"Each department had the family at its core, but each had a different vision statement. We didn't have good interdisciplinary teamwork, and discharge planning accountability was variable," says **Brenda Shepherd-Vernon**, MSW, LICSW, director of social work, child life, language services, and pastoral care.

In 1998, the year before the redesign was implemented, the hospital was facing a tough managed care market and competition from other facilities in the region.

"Denials were way out of control, totaling more than $8 million a year. The managed care payers perceived our facility as providing inefficient and very expensive care," Daymont explains.

High-risk and high-dollar cases were a problem for the hospital. One case that grabbed the attention of management was a patient who accrued more than $1 million in charges but did not meet medical necessity.

When the administration mandated a clinical

redesign, the team began looking at ways to improve inpatient care coordination.

Working with Karen Zander, RN, MS, CS, CMAC, FAAN, principal and co-owner of the Center for Case Management in South Natick, MA, the team integrated the case management, utilization management, and social work functions into one cohesive department.

Kathleen Chavanu, the hospital's executive director of quality and clinical support services, led the effort to redesign the hospital's clinical resource management model.

"Our goals were to reduce denials and length of stay, to improve care coordination, to hold all team members accountable, improve our relationship with external payers, and to change their perception of the hospital," Shepherd-Vernon says.

Two case management positions

Under the redesign, there are two case management positions:

- **Case Managers I** have a bachelor's degree and are responsible for utilization review and denials management, working with the on-site review nurses, interfacing with the health care team and insurance company, and managing reviews of observation and admission status.
- **Case Managers II** have a master's degree and are responsible for family meetings, discharge planning, and coordination of care while the patient is in the hospital.

A Case Manager II and a social worker are assigned to each unit, typically covering 26 to 28 beds. The exception is the neonatal intensive care unit, with 40 beds.

The team can cover the extra load because the patients have a longer length of stay and there is more time to arrange post-discharge services, Daymont explains.

"We had to educate many of the people in the Case Manager II positions. They were strong clinical nurses and educators but were not familiar with utilization management. We had to educate them to start thinking about resource management," she adds.

Social workers are on site at the hospital from 1 a.m. to 8 a.m. Monday through Friday.

The unit-based social workers are on duty from 8 a.m. to 5 p.m. In addition to their duties on the unit, they respond when called to work with the outpatient services team.

A social worker covers the emergency department from 4:30 p.m. to 1 a.m., responding to trauma codes and handling other issues in the emergency department.

Creating interdisciplinary teams

Two social workers split a part-time position, covering the hospital for 10 hours a day on weekends. Working hours for case managers are 8:30 a.m. to 5 p.m., but the Case Manager II staff often work longer. Case Manager IIs are on call for their unit Monday through Friday after hours.

A weekend case manager is on call but comes to the site if the census is high.

To increase communication and facilitate patient care, the hospital implemented interdisciplinary clinical resource management teams that make rounds on all units. The team includes the physician, social worker, case manager, and nurse.

"The rounds were added in after the initial implementation of the program. When we first redesigned the model, we had people who were together on a team but who were engaging in parallel play. There was not a formal process for sharing information, and there was a lot of distrust between the different groups," notes Shepherd-Vernon.

The team holds clinical resource management rounds every day after the physician rounds. The nurses, social workers, and case manager on each unit establish a plan of care for the day and for each patient's stay.

"Everybody leaves the rounds with an understanding of what they have to do that day," adds Daymont.

The goals of the redesign project were to reduce length of stay and denials and to establish clinical pathways with outcomes. The department installed a computerized documentation system and developed databases to make it easy to run outcomes reports and analysis.

Implementing clinical pathways

The unit-based teams focused on looking at denials, how they were being managed, and why they were happening. They provided those data to the clinical resource management team.

"We looked at where the areas of problems were. We can provide information on length of stay by unit and by diagnosis. The high-volume diagnoses seemed to be the area where we didn't

have a good handle on coordination of care and length of stay," Daymont explains.

The hospital uses the Pediatric Health Information System (PHIS) database — a collection of data from a number of freestanding pediatric academic medical facilities — to benchmark its outcomes.

"If the length of stay was above the PHIS average, it indicated we were not providing efficient services and that was an area where we needed to focus," Daymont continues.

Each clinical resource management team chose clinical pathways to implement, ultimately implementing 52 clinical pathways hospitalwide with the goals of facilitating coordination of care and improving length of stay and clinical outcomes.

The hospital's new onset diabetes pathway dramatically reduced the length of stay and improved coordination of care to the point that a large payer contracted with the hospital to be its disease management entity for children with diabetes.

Under the new system, the social workers begin discharge planning at the beginning of the stay, anticipating any psychosocial issues or other problems that could affect the patient and be a barrier to discharge.

"We have become more proactive as opposed to reactive to discharge and family issues as soon as the patient is hospitalized," Shepherd-Vernon says.

The team developed the social work initial assessment and risk tool, a communication tool that clearly states the pertinent information that all team members need to make assessments.

Barriers to discharge are identified

The social work assessment identifies barriers for discharge, providing a clear understanding for all team members what the impact of the patient's condition and hospitalization is likely to be on the family, Shepherd-Vernon says.

"We get an idea from admission what the potential problems may be for the family and document it clearly in the medical record," she adds.

For instance, the social worker may find out that the patient's mother uses a walker and may have a problem taking care of the child upon discharge. The social work assessment communicates this to the case manager, who may not have met the mother.

The department's family service associates assist the social worker and help identify resources needed to plan for the patient and family.

"Families of hospitalized children often have a lot of different things going on in their lives, and we don't always get the correct information at admission. We were spending a lot of time learning about the family and what kind of support they need. This role is critical in helping stretch social work resources," Shepherd-Vernon points out.

The social work team developed a computerized data collection tool to help track how many families they assist and what they do for them.

"We needed to know more about our families and to be able to work with families at a greater level than in the past," Shepherd-Vernon adds.

"This tool helped us compile information about what the staff are actually doing. It also includes readily accessible resource information that helps us move from a passive, traditional social work model to a proactive, efficient, and streamlined work force," she explains.

In 2001, social workers performed an assessment on 26.9% of patients who stay in the hospital 48 hours or more. By 2004, the figure had jumped to 73.9% of patients who are assessed by social workers. The family services associates and the computerized data have enabled the department to increase the figure with the same 10.5 full-time equivalents, Shepherd-Vernon says.

The case management department developed the Interdisciplinary Patient and Family Education and Discharge Planning Record, called the "pink sheet" because it's printed on bright pink paper.

The case managers record discharge planning activities, what has been done, and what the next step is. If the case manager is working with another family or the discharge takes place after hours, the nurse or physician handling the discharge can readily see the plan.

"One of the benefits for the entire team with the pink sheet is that it makes clear what needs to happen when patients are discharged," Daymont explains.

Interdisciplinary review board established

"It the patient is discharged after hours or in the evening, the hospital staff have the phone number for the post-acute care provider, what services the patient needs, and the information the agency needs," she adds.

The hospital established an interdisciplinary complex case review board that includes representatives from business operations, legal, admission, financial, as well as social work and case management.

The team meets monthly or twice a month if necessary to review complicated and complex cases and come up with interventions that will help move the patients through continuum.

For instance, the hospital frequently has patients who are on a social hold, waiting for a child protection agency to make the next move.

"In the past, staff who were working directly with the patient got frustrated because they felt that nobody was listening. The complex case review board gives them a forum in which to discuss the options for these patients," explains Shepherd-Vernon.

Since implementation, the hospital has been able to retain 40% of total charges.

"The legal department has been instrumental in having discussions with the legal representation for the District of Columbia Protective Services agency and, in some cases, the family court superior judge," she adds.

"We've had local agencies reimburse us for charges that are being denied because they don't meet medical necessity, thanks to their intervention," Shepherd-Vernon says. ■

Early '100,000 Lives' participant sees benefits

Facility sees dramatic reductions in ventilator use

One of the better known ongoing collaborations in the United States is the Cambridge, MA-based Institute for Healthcare Improvement's (IHI) "100,000 Lives Campaign," whose goal is to save 100,000 lives through targeted QI interventions by June 14, 2006. The campaign, launched in January 2005, features "Six Changes That Save Lives":

- Deploy rapid response teams (called when a patient seems to be losing ground but isn't yet a true emergency).
- Deliver reliable, evidence-based care for acute myocardial infarction (AMI).
- Prevent adverse drugs events (ADEs).
- Prevent central-line infections.
- Prevent surgical-site infections.
- Prevent ventilator-associated pneumonia (VAP).

To date, more than 2,300 hospitals have enrolled in all 50 states, accounting for about 50% of all U.S. hospital beds, according to IHI. If all U.S. hospitals joined, says IHI, 183,000 lives could be saved every year.

One of the early adapters, Hackensack (NJ) University Medical Center (HUMC), a teaching hospital in northern New Jersey with nearly 700 beds, already has started reaping the benefits.

"It's incredible," says **Regina Berman**, director of process improvement. "It goes to the concept that a group mind is better than a single thought. We have a brain trust — some of the best minds in the country — to sit down with to share. They include great scientists, operations people, and pharmacists. We are benchmarking and sharing collaborative data all over the place."

A good foundation laid

Berman notes that one of the reasons why the program has been effective so quickly is that HUMC already had laid a strong foundation. "We've been part of the IHI network for some time, because we are a 'Pursuing Perfection' [another IHI initiative] hospital," she explains.

"In December [2004], we were down at the annual forum and heard Don's [Berwick, head of IHI] kickoff speech [on the campaign]. It was quite impassioned and very moving, so we signed up immediately," Berman adds.

HUMC already had worked at reducing AMI mortality and, in fact, had some of the lowest rates in the country, she reports.

"We focused on our systems for patient care by starting to work with first responders to transmit vital information even before the patient arrives," Berman relates. "Plus, thrombolysis used to be the gold [clot-busting] standard; now, we do angioplasty." HUMC also was part of the [Centers for Medicare & Medicaid Services] demonstration project, "and were in the top decile in each category," she adds.

HUMC already has deployed its rapid response team. "Our understanding is that it should be the senior rehab nurse, a critical care person, who leads the team, because others feel more comfortable calling them," Berman observes. "In some cases, you can use physicians, but we feel nurses may be reluctant to call a physician-led team."

There are clear benefits to a rapid response

team, she says. "Sometimes, you have an intuitive sense of a change in patients — they just do not look good; they are anxious, but you do not have objective data yet. A nurse may hesitate to call a doctor, but if they can call and say 'I'm worried' and someone will come, it tends to help capture a downward spiral more quickly."

Berman says typically, from the time a patient is perceived to have a change in status to the time he or she actually expires, there is about an eight- to 12-hour window. "So the idea is to catch that change as early as you can," she asserts.

One of the areas in which HUMC has seen dramatic improvement, and in which there is a slight overlap with the start of the 100,000 lives campaign, involves VAP infections. "It's what we call our 'ventilator bundle,' says Berman — five steps every day at exactly the same time. "We've not only been able to prevent pneumonia, but we get our patients off the ventilator more rapidly."

When the initiative began in October 2004, she recalls, "We might have had 12 patients on ventilators in the ICU." Now, Berman points out, "There may be one or two."

A similar approach is being used regarding central lines and avoiding bloodstream infections — keeping patients connected for as short a time as possible. "We want them connected as long as they need to be, but not one second longer," notes Berman. Success in this area involves proper technique and preparation of the site before the line is inserted. "We're creating a video for the staff to show them the best technique," she says.

Ongoing QI efforts

Another evidence-based practice HUMC is adopting involves surgical infection prophylaxis. "The evidence suggests that instead of shaving patients, you should use a clipper," Berman says. "Patients used to be shaved the night before surgery, and when they got nicks, bacteria got in them. Now, no one gets shaved until they are up in the OR and antibiotics have been started."

HUMC is working on further improvements in medication reconciliation, to help prevent ADEs.

"The concept here is to do everything we can to include a call to the patient's pharmacy for a complete and accurate list [of the medications the patient is on]," Berman explains. "Throughout their stay, changes are updated electronically, so we can ensure when they go home, they know exactly what to take, how often, and who to check with to make any changes."

Part of that effort, she adds, is to try to get patients to take more responsibility for compliance. "For our heart patients, we've created pillboxes and created a sample of what a day looks like," she adds. "We'll take simple approaches to see what works to make things better."

Joining the 100,000 lives project involves no fee, and paperwork is minimal, IHI says. ■

OSHA plans 4,400 unannounced visits

Some 4,400 workplaces deemed "high hazard" will receive unannounced comprehensive inspections from the Occupational Safety and Health Administration (OSHA) during fiscal year 2005-2006. OSHA announced in August its 2005 site-specific targeting (SST) plan will focus on

COMING IN FUTURE MONTHS

- Guiding cancer patients through their treatment
- Helping the chronically ill make better lifestyle decisions
- Use e-mail to enhance your case management services
- Disease management for morbidly obese members

CE questions

13. Blue Cross and Blue Shield of Illinois' Blue Care Advisor package allows members which of the following features?
A. access to a Personal Health Manager
B. access to the Ask a Nurse feature
C. access to the Ask a Trainer feature
D. all of the above

14. According to Kay Sherwin, RN, CCM, director of client services for Integrated Healthcare Information Services, what percentage of any given population needs case management?
A. Between 0% and 0.8%
B. Approximately 1%
C. Between 1.5% and 3.5%
D. Approximately 4%

15. According to Mindy Owen, RN, CRRN, CCM, which type of patient may represent the most risky situation?
A. a low literacy/low health literacy patient
B. a highly literate/high health literacy patient
C. a highly literate/low health literacy patient
D. a low literacy/high health literacy patient

16. A clinical redesign at Children's National Medical Center resulted in a 15% drop in length of stay and a 66% reduction in denials.
A. true
B. false

Answers: 13. D; 14. B; 15. C; 16. A.

approximately 4,400 high-hazard work sites for unannounced comprehensive inspections over the coming year.

Over the past seven years, OSHA has used an SST inspection program based on injury and illness data; this year's program is based on data surveys from 2004, drawn from approximately 80,000 employers' injury and illness numbers.

The 2005-2006 program will initially cover about 4,400 individual work sites on the primary list that reported 12 or more injuries or illnesses resulting in days away from work, restricted work activity, or job transfer for every 100 full-time workers (known as the DART rate). ■

CE objectives

After reading this issue, continuing education participants will be able to:

1. Identify clinical, legal, legislative, regulatory, financial, and social issues relevant to case management.
2. Explain how those issues affect case managers and clients.
3. Describe practical ways to solve problems that case managers encounter in their daily case management activities. ■

CE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **December** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a certificate of completion. ■