HOSPITAL CASE MANAGEMENT™

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

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IN THIS ISSUE

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Make sure your patients understand their medication, discharge plan

Low health literacy contributes to readmissions, ED visits

As a case manager, you're likely to be one of the last people to see patients before they leave the hospital. This gives you the opportunity to make sure they understand their treatment regimen, their follow-up appointment, how to take their medicine, and other components of the discharge plan that can help them recuperate rapidly and avoid readmissions or emergency department visits.

Low health literacy, or lack of understanding of the treatment regime, costs the health care system an estimated $58 billion a year, according to the Institute of Medicine in its 2004 report *Health Literacy: A Prescription to End Confusion*.

Low health literacy is associated with more hospitalization and emergency department use, increased adverse drug reactions, and a decrease in the use of preventive services, according to the report.

Health literacy is the degree to which individuals are able to obtain, process, and understand basic health information and services needed to make appropriate health decisions, according to the U.S. Department of Health and Human Services.

The National Assessment of Adult Literacy by the U.S. Department of Education, conducted on more than 19,000 adults, showed that about one in 20 adults in the U.S. could not answer simple test questions or could not take the test because of language barriers.

Even among college graduates, 3% demonstrated "below basic literacy," meaning that they couldn't perform skills such as locating easily identifiable information in a short paragraph or reading a prescription label.

But even people who are highly literate can have low health literacy and not understand complex medical terms, points out **Gloria Mayer**, RN, EdD, president and chief executive officer of the Institute for Healthcare Advancement (IHA) based in La Habra, CA.

"Health literacy is a huge problem. Many times case managers may

feel like their patients aren't compliant, but it's a health literacy problem. They simply don't understand what they are supposed to do," Mayer adds.

"An increasingly important trend is to give patients more ownership of their own health care outcomes and to make them understand that they are responsible, in part, for how things go for them medically. This puts a higher burden on us to provide education in clear English that they are capable of understanding," says **John Rogers**, MD, chairman of the department of medicine for Good Samaritan Hospital in Baltimore.

Put yourself in your patient's place and remember what it's like when you deal with someone in another profession, such as a computer technician or an automobile mechanic who uses terms you don't understand.

Age, disability, language, culture, or the sheer stress of being in the hospital can block a patient's understanding of health information, says **Helen Osborne**, MEd, OTR/L, president of Health Literacy Consulting, a Natick, MA, firm.

Don't make an assumption of literacy, no matter how bright the patient seems to be, Rogers advises.

While it may seem that the immigrant population or people with low-level jobs would be the ones affected by low health literacy, middle class people with good jobs may have trouble understanding, Mayer points out.

Rogers tells of a patient with diabetes he followed for a year. She seemed to understand her instructions on how to give herself insulin shots and fill out a flow sheet showing blood sugar levels. "I found out she was filling out the flow sheet into the future, recording her blood sugar levels for a week or two ahead of time, trying to please me. She didn't understand why she was doing it," he said.

Patients' lack of understanding of their condition and the health care system often starts at admission, when the patient is the primary source of his or her medical history.

"We've looked at medication history as provided by different people and have found a big variation," Rogers says.

For instance, a patient comes into the emergency department and tells the admissions person what medications he or she is taking. Later, the spouse comes in and brings a bag with the medication. The two versions are likely to be different and may not include herbal medicine or over-the-counter drugs.

"Every hospital and health care system should be trying to educate people to get into the habit of bringing medication lists or the actual medications with them," Rogers says.

Discharge instructions are particularly crucial to patients' well-being after they leave the hospital, and it's an area where case managers have the potential for the biggest impact.

"With the current time crunch in health care, the decision to discharge a patient is made; and an hour later, we're in the middle of the discharge

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process. We need to think ahead and make sure the discharge instructions are clear and have the patient or a responsible caregiver demonstrate that they understand them," Rogers says.

Osborne points out that while most hospital literature is written for people at the seventh- to 12th-grade reading level, millions of adults in the United States can't read above the fifth-grade level.

Even the signs in the hospital pose difficulties for some patients, Mayer adds. "A patient may know he's going to see Dr. Smith but he can't read 'radiology' or 'neurology,'" she says.

Make sure your patient education material is simple and easy to understand, with a lot of illustrations. Examine all written materials you give to patients. Mayer points out that materials produced by drug companies may be too complicated for the average patient to understand but so may hospital discharge instructions.

For instance, directions for medication may say, "take with food" rather than "take with water and food."

Patients who take direction literally, particularly the elderly, may believe it means the medication should be folded into food, Mayer points out.

Test materials on intended readers first

When you develop written materials, test them on the intended readers as you go along. Test your initial draft of the materials, then make revisions and test it again.

"No writer, no matter how clever he or she is, can be sure the reader will understand," Osborne points out.

Use formal focus groups to test your materials or just ask people sitting in the waiting room to look them over and answer questions.

"In our book, we use 'pee' instead of 'urine.' We had five focus groups look at the material and they all recommended using 'pee' because everybody understands what that is," Mayer says.

If your word processing software has a spell-checking function, look for words that are highlighted because they're not in the software's dictionary and eliminate those.

Case managers should work with other professionals within the hospital as well as outpatient providers to make sure that everyone who works with patients uses the same wording and language, Osborne suggests.

For instance, it may confuse patients if one person says his or her condition is "hypertension" and another calls it "high blood pressure."

Use pictures and a model to show your patients what they need to do after discharge. Make sure they understand, and if not explain it in other ways until they do.

Use large type for your older patients and adjust the content to meet their learning needs, Osborne suggests.

Never ask patients, "Do you understand?" It's too easy for them to say yes when they do not understand.

One way to make sure you're getting through when you give oral instructions is to use the "teach-back" method, asking your patient to explain each key point, "to make sure I explained it correctly," Osborne advises.

Preface your questions by putting the burden on yourself, rather than suggesting that the patient may not understand, she adds.

For instance, ask the patients how they would explain their medication regime to someone else or to show you the suggested exercises.

If you find that the person doesn't understand completely or correctly, go over it again until he or she understands.

Take a patient's age into consideration and do your education of elderly patients in short sessions, repeating the information, and confirming their understanding along the way, Osborne suggests.

"As people go through the life cycle, their way of learning changes, their hearing and eyesight may not be as good; their tactile senses may not be as good; and they tend to learn in shorter bursts," Osborne explains.

Suggest that your older patients bring along someone else when you do patient teaching.

"Older people have a harder time reading and comprehending, as well as poorer eyesight," Mayer says.

Keep in mind that while you talk about the same types of information all day long as a professional, the patient you're talking to is hearing it for the first time.

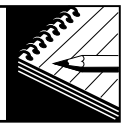
"Clinicians shouldn't use medical jargon. In a study by Dean Schillinger, MD, assistant professor of medicine at the University of California, San Francisco, a doctor explained dialysis to a patient, but when he was asked to repeat what he learned, he said he just knew he had to do something daily," Mayer says.

"Health professionals tend to have their own jargon, their own way of talking in shorthand to each other. It's an efficient way to communicate

with other clinicians but it's not effective when they talk to patients," Osborne says.

"For instance, PET scan is an easy way to say 'positive emission tomography' and is understood by people in the medical profession, but someone in your emergency department who's been hit by a car might think of a furry little animal when they hear the term. Drawing blood has nothing to do with crayons, but the medical profession uses it in a certain way and assumes people will understand" Osborne says. ■

GUEST COLUMN



Take the lead in filling your patients' 'perception gap'

Low health literacy affects many people

By **Mindy Owen**, RN, CRRN, CCM
Chair, Commission for Case Manager Certification

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 that 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 adds to the fragmentation and many times leads 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 experiencing 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 impacts 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/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 or less frequently than prescribed. Stress, anxiety, and other emotional causes also can affect 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 or 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 chair of the Commission for Case Manager Certification (CCMC). She also 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.] ■

Outcomes managers take lead in quality initiatives

Projects aimed at improving patient care and safety

Just six months after North Mississippi Medical Center began a project to ensure that patients received the recommended medications after a heart attack, the hospital's mortality rate for heart attacks had dropped dramatically, from 15.3% to 8.2%.

The project and its success is just one example of how the hospital's outcomes managers, experienced RNs who take the lead in quality initiatives and developing order sets and protocols, have helped the rural health center in Tupelo, MS, focus on quality improvement.

The hospital received a site visit last year from the Baldrige National Quality Program and recently received the American Hospital Association McKesson Quest for Quality Prize in recognition of its leadership and innovation in quality, safety, and commitment to patient care.

Outcomes managers are assigned by service line and act as a liaison between the physician group and other clinicians. They research the medical literature, looking for new guidelines and new standards of care, then collect and run data to see how the hospital is doing.

"We look for opportunities for improvement in processes. These are things that the physicians and nurses recognize but don't have time to deal with. We make a comparison between how we do something and the standard of care, and that is where we go to work," says **Jan Englert**, RN, leader of outcomes management.

Projects have included everything from eliminating hematomas after a heart catheterization to documentation and coding initiatives to working with physicians on specific mechanisms to help them remember to prescribe beta-blockers for heart attack patients.

"It runs the gamut. The outcomes managers do many different things during a given day within the context of their job description," Englert says.

The hospital looked at administration of aspirin, beta-blockers, and ACE inhibitors after a heart attack before those recommended treatments became part of the Centers for Medicare & Medicaid Services (CMS) core measures.

"One set of core measures is based on American Heart Association evidence-based medicine. When they were announced, we were already looking at these indicators. We don't

think we should wait around for somebody to mandate that we follow the best practices," Englert explains.

Kim Jones, RN, BSN, cardiology outcomes manager, spearheaded the heart attack medication project. She started by examining patient data to find out just how often the aspirin, beta-blockers, and ACE inhibitors were administered.

"At first, some physicians didn't believe our data was accurate. We had other physicians examine the charts and affirm what our research had shown," Jones says.

Jones and her team created a "red-ticket" project, creating a tool that indicates which physicians either fail to prescribe the recommended medications after a heart attack or fail to document in the chart why they were contraindicated.

The tool is a red sheet of paper that asks, "Did we define a heart attack in this patient?"

If the answer is "yes," the tool lists the recommended practices in the core measures with a place to check each if it wasn't administered.

If they didn't have a beta-blocker, the outcomes manager checks the box that says there is no contraindication in the medical record. If physicians get a red ticket, it's documented in their outcomes information and may affect their re-credentialing.

The project had an unexpected benefit — ensuring that all heart attacks were coded correctly and increasing reimbursement.

When she examined the data, Jones determined that physicians were not always defining a myocardial infarction (MI) on the chart.

"If the patient had a huge MI, the physicians would document it, but with smaller heart attacks, they were writing down acute coronary syndrome. There wasn't a code for acute coronary syndrome, so those heart attacks were not included in our statistics. The tool helped identify things that it was never intended for," she says.

After determining that some heart attacks were being documented as acute coronary syndrome, Jones arranged for the laboratory to send her a list of all patients whose cardiac enzymes were elevated. "I started looking at the charts and determining when the patient had all indications of a heart attack, but the physician didn't list a diagnosis of heart attack on the chart," Jones says.

Instead of around 500 heart attacks a year, Jones determined that about 900 patients were admitted with heart attacks each year. Adding the correctly documented additional patients lowered the hospital's MI mortality rate.

The initiative increased reimbursement as well as improving patient care, Jones points out.

"Coders can't code acute coronary syndrome, so we weren't getting paid for those patients," she says.

Jones attributes the dramatic drop in the mortality rate to more physicians prescribing the recommended medications and more accurately charting smaller heart attacks.

When she began the project, only about 50% of heart attack patients were getting beta-blockers. After the project was implemented, the figure increased to 95%.

Now the hospital consistently is in the 99th percentile on the core measures for heart attack.

At North Mississippi Medical Center, no one department is responsible for quality. The hospital has decentralized quality improvement and taken it to the bedside, Englert reports.

"The outcomes nurses make sure that quality of care occurs from the time the patient comes in until the patient leaves. Traditionally, people tend to wait for a quality person to come around with a check list. But for a patient to receive quality of care all the time, every member of the staff needs to understand and work on quality," Englert says.

The outcomes managers get a project started and work with the pharmacists and other appropriate disciplines to get it implemented. Later, the outcomes managers check back to see how things are going and which physicians have adopted the recommended actions.

At one point, Englert and another nurse were the only outcomes managers. After several successful initiatives, the organization assigned seven nurse case managers into outcomes manager positions. "Now instead of a centralized quality process, the outcomes case managers are dedicated to each service line," Englert says.

A recent project ensures that every patient who is admitted to the hospital is screened for deep vein thrombosis (DVT) and pulmonary embolism (PE) risk factors through an automated nursing admission assessment record.

"We had quite a few instances where patients had complications and prolonged hospital stays due to DVT/PE, and we felt like we could improve our outcomes. When we looked at how many patients received appropriate prophylaxis, we found that the numbers were low," says **Karen George**, RN, BSN, clinical outcomes manager for the medical service line.

George worked with Dereck Young, clinical

(Continued on page 43)

CRITICAL PATH NETWORK™

Case managers take the lead in throughput initiatives

Hospital ranks high on satisfaction, timely care

At Sioux Valley Hospital USD Medical Center in Sioux Falls, SD, case managers often take the lead in developing ways to move patients safely and effectively through the continuum of care.

"Throughput is an issue that is addressed collectively in our organization. It doesn't belong only to case management, the emergency department, or surgery, but having the case manager out there on the front line, developing a close relationship with the physicians and the bedside staff facilitates the ongoing process of ensuring that patients move through the hospital in a timely fashion," says **Diana Berkland**, RN, MS, CNS, vice president and chief nurse executive for the a 487-bed tertiary care hospital.

For the third consecutive year, J.D. Power & Associates recognized the hospital under its Distinguished Hospital Program for the hospital's commitment to providing patients with an outstanding inpatient experience. The hospital exceeded national benchmarks for inpatient satisfaction and performed particularly well compared to the national study in providing care to patients with speed and efficiency.

How it's done

The entire hospital focuses on throughput issues, and the case management staff have developed initiatives, using comparative data to identify issues, and then coming up with long-term solutions.

They look at length of stay and other indicators by case manager, by individual and group practice, by unit, and for the hospital as a whole and compare that to regional and national benchmarks.

"Length of stay, direct cost, average cost, severity of illness, laboratory, imaging, and pharmacy are all variables that we benchmark to other hospitals to identify opportunities for improvement," says **Doreen Miller**, APRN, BC, MS, CNS, director of geriatric services and case management.

The clinical outcomes of patients and safe passage through the organization are the driving factors for the initiatives.

For instance, the orthopedic unit and other hospital departments collaborated to create the Center for Joint Success, a process improvement project to move joint replacement patients more efficiently through the hospital.

The nursing unit, physicians, case managers, social workers, surgical services, pharmacy, therapists, and the hospital's marketing department collaborated on the project.

"We had looked at our length of stay and realized that we had room for improvement," Miller says.

All of the disciplines were involved in planning and making changes. "By streamlining the service, we now have physicians working off a similar plan of care and an integrated pathway," Miller explains.

The pathway schedules surgery for joint replacement patients on specific days (Monday and Tuesday) to facilitate patient flow.

Patients who are in the Center for Joint Success program come to the hospital, along with their caregivers (or coaches), a month before surgery for an intense educational program by the interdisciplinary team, which includes the nurse case manager, social worker, pharmacist, physical therapist, and someone from surgical services.

The physical therapist teaches the patient and coach pre-surgery exercises to strengthen the

patient's muscles so he or she can recuperate more quickly.

"If a patient has to learn the post-op exercises right after surgery when he may not feel well, it's much more difficult. We work on this with them before surgery so they'll be prepared," Miller says.

The pharmacist reviews all their medications to identify any pre- or post-surgical issues and to communicate with the physician and team. The goal is to have the patient understand the medications prior to hospitalization.

The case managers and social workers address their discharge needs and any issues that might be barriers to recovery.

"We find out if they have a caregiver at home and if not, we work on that ahead of time instead of at the point of discharge. We find out where their bathroom is in connection with the rest of the house, how easily it is accessible, how many steps they have to climb, and any adjustments they may need to make in the home," Miller says.

The equipment is ordered, and any services the patients will need after discharge are all arranged before admission. If they need nursing care or therapy beyond the hospital, it can be arranged in advance.

"Once they're here, they know what is happening and they can move through quickly," Miller says.

The average patient in the Center for Joint Success stays about three days.

Physician support

In addition to decreasing the lengths of stay, the project has improved utilization of beds and human resources as well as supplies for taking care of the patients, Berkland says.

"The patients love it. They come together for class as a group based on their week of surgery and meet each other prior to surgery. They see each other in the hospital, and can better participate in their care because they know what is going on," Miller adds.

The team started with the hospital's own physician clinic and worked collaboratively with those doctors to create a plan of care that calls for similar patients having surgery on the same day of the week.

"We started small and brought in just three or four patients at a time. They like the process and are so happy they're recommending our hospital to their friends," Miller says.

"The initiative has grown and now physicians are targeting those surgery days," she says.

The Center for Joint Success is designed for any patient with joint replacement surgery and is located on a nine-bed wing.

Patients whose surgery is not scheduled on Monday and Tuesday receive similar care but are not part of the center's experience.

"One of the key concepts is that this is elective surgery and the patients have time to prepare. If they come in well prepared and have done strength training on their alternative leg, it makes a huge difference. We look at it as investing the patient as a partner in the success of his care," Miller says.

The case management staff operate on a triad model with a nurse case manager, social worker, and utilization management analyst. Case managers all have a clinical specialty and work within a geographic location. Depending on the needs of the patient, they may follow the patient if they are moved to another unit.

They work closely with the physicians to manage patient care in real-time and ensure that patients move through the continuum of care on a timely basis.

The hospital publishes a daily bed briefing that is e-mailed to key stakeholders. It contains information about scheduled admissions, discharges, surgical patients who need to be placed, and the hospital's staffing capability for that day.

The case managers on each unit contribute information each day about patients who are scheduled for discharge.

"The case managers design their workflow based on the unit needs, and the clinical care coordinators are doing the same thing right alongside of them," Miller says.

For instance, if a patient on the surgical unit has met the discharge criteria the surgeon established, either the case manager or the clinical care coordinator discusses it with the surgeon and facilitates discharge orders.

"The case manager isn't the only one who is responsible for working with the surgeon. We have a real-time concept of managing patient throughput. The case managers and the clinical care coordinators work together to see that whatever needs to happen gets done," Miller says.

Moving patients efficiently through the hospital not only saves money, but it's also what's best for the patient, Berkland says.

Everybody in the hospital, starting with the emergency department and including each

nursing unit, is responsible for ensuring that the patient moves through the hospital as efficiently as possible.

"It's not that anyone is pushing the patients out. Everyone is helping pull them through. Whether it's in the operating room or the emergency room, we strive to work in that direction. All of nursing is on the same page and all are working toward the same end, moving the patient through in a timely manner, meeting their needs, and making good use of their time and resources," Berkland says.

Case managers are the drivers of the interdisciplinary team and work with the physicians on the medical plan of care. Each nursing unit handles things a little differently because of the different needs of its patient populations.

The team on each unit has a daily huddle that includes the case manager, social worker, utilization management analyst, the clinical care coordinator, bedside nurses, and other team members when appropriate.

They make a quick review of patient needs for that day and discuss any new developments or changes in the plan for the day.

"The team members who need to know what is going on for the day attend. This is not the nursing unit report. It's a meeting of key decision makers and people who carry out the plan of care," Miller says.

Interdisciplinary team meetings

Each unit also has a more formal and lengthy interdisciplinary team meeting in which individual patient's plan of care are discussed.

The interdisciplinary team meeting is a more comprehensive review of patient care and patient needs. It's scheduled routinely and as needed on each unit so the team can discuss the patients who have the highest priority. Physicians may attend the meetings if needed, and the meeting can be scheduled around the physician's time.

Another interdisciplinary team meeting takes place each day for the subset of patients seen by the hospitalist service.

At Sioux Valley Hospital USD Medical Center, the case managers operate in a differentiated nursing practice with a shared governance model. The hospital achieved nursing magnet status two years ago.

The differentiated practice model for nursing includes the nurse case managers, the clinical care coordinators who manage activity on the unit and handle some daily staffing duties, advanced practice nurses with master's degrees, and bedside nurses.

Under the hospital's shared governance structure, each nursing unit elects a "senator" who attends monthly meetings where decisions are made about nursing practices at the hospital.

The hospital uses integrated clinical pathways and order sets grounded in evidence-based practice. ■

Tiered structure helps ED improve flow, satisfaction

Department cuts LOS by 40 minutes

Between 2001 and 2005, average length of stay in the emergency department (ED) at Northwestern Memorial Hospital in Chicago had dropped from 85 minutes to 45 minutes. Throughput has fell from 308 minutes to 230 minutes during the same period. In addition, patient satisfaction (Press Ganey Associates, South Bend, IN) scores have increased from 74.6% to 84%.

This improvement was due to a number of factors, notes **James Adams**, MD, chairman of the department of emergency medicine. For one, the department instituted a comprehensive Six Sigma initiative during that time period. But perhaps one of the most unique strategies, and one that has clearly had an impact on the aforementioned improvement, was the redesign of the ED management structure.

"We have four nurse managers, and each has a subsegment of staff and shifts," Adams explains. The new structure, he adds, was adopted in fall 2003. The nurse managers are assigned as follows:

- There is a night manager who works 11 p.m.-9 a.m. four days a week.
- There is another evening manager who works from 2 p.m.-midnight four days a week.
- There are two day managers, one of whom manages the observation unit (OU) and also has ED staff, while the other works entirely in the ED. Both work 8 a.m.-5 p.m., five days a week.

Managers split responsibilities

Their managerial responsibilities are further divided, explains **Deborah Livingston**, RN, MS, director of emergency services. "We've taken

major pieces of what managers do, like staffing, salary and budget, quality management, and equipment, and assigned those responsibilities to each of them," she says.

Salary, budget, and staffing are assigned to the night manager. Quality management has been assigned to the evening manager. Equipment is assigned to the day manager who doesn't have the observation unit. The person who is upstairs with the observation unit and downstairs with the ED also manages staff educators, Livingston says.

They want to take advantage of efficiency in educational and orientation opportunities upstairs and downstairs, she adds. "Why run two programs when you only need one?"

These responsibilities were assigned based on expertise, Livingston reports. "We put a person who was incredibly meticulous with salary, budget, and staffing," she says.

Livingston also has a scheduler who works with her. "We have quality nurses in the department who work with the quality manager," she says. They do all the callbacks for left without being seen (LWBS), radiology callbacks, and nurse quality data collection.

'Double-duty' valuable

The assignment of a single manager for the observation unit and part of the ED staff was an extremely important part of the improvement process, says Livingston. "It really helped us make initiatives between the two areas flow better, as she has staff and influence in both areas," she says. "It's a big part of why we have been so successful."

One example is the "orange" or middle-triage patients. (Northwestern has a five-level, color-coded triage protocol.) "These are mostly young, otherwise healthy patients with abdominal pain who would normally wait the longest," says Livingston. They often need a lot of tests and scans, she says.

The patients who go from the ED waiting room to the observation unit go there for their ED care, Livingston explains. "We call it 'ED2,'" she says. "We have an emergency room attending up there at all times these patients are up there. They are registered as ED patients with a special code that denotes their different location."

This change drives the culture that patients should not wait, Adams says.

After they have received their ED evaluation and care, if they need observation care, the patients are admitted to the observation unit for outpatient observation. They stay in the same room and bed. The patients are happy, as they avoid long waits in the ED and they have a bed and a TV, says Livingston.

Inpatient holding patients (select admitted patients waiting for an inpatient bed) are also placed up in the observation unit. "This unloads the ED and improves throughput, so patients don't wait as long to be seen," she explains, "With inpatient beds very tight, the [observation unit] is our most consistent outflow opportunity for the ED. We are creatively maximizing its use."

All programs affected

Livingston notes that the tiered structure not only directly affects performance in the ED, but also contributes to the success of specific Six Sigma initiatives.

"It's great to have more than one manager to work on these initiatives we are making," she says. "We always team a nurse manager with a physician, and this gives us more people to go around."

Personally, Livingston is extremely thankful for the new structure. "This would be a lot of work for one manager to be doing," she concedes. "It also helps the staff because they have a go-to person for whatever they need. It creates much less confusion about who is doing what."

Of all the improvements engendered by the new structure, the most important are those that impact wait times and throughput, Adams asserts. "Quality in the ED is time-based," he says. ■

(Continued from page 38)

pharmacy specialist, to research the medical literature on DVT prophylaxis and compile the hospital's data, comparing them to benchmarks.

In many cases, patients were receiving either inadequate prophylaxis for DVT or none at all, Englert says. "We had patients who needed to be receiving pharmacological prophylaxis who didn't even have anti-embolism stockings. The literature on DVT clearly indicated that just being in the hospital places these patients at risk," she explains.

George and Young worked with physicians, nurses, and other disciplines to develop the protocol. They met with physician groups and nursing units throughout the hospital system to educate them on the reason for the DVT protocol, what it does for patients, and to share outcomes data from the pilot project.

"They attended at least 50 different meetings and spent a lot of time gathering data and creating the presentation. The whole project took about a year from inception to the time it was rolled out across the system," Englert says.

The DVT protocol was piloted on two units before it was rolled out in the entire hospital. The protocol was so successful that it has been integrated systemwide.

Every patient admitted to the hospital is screened for DVT/PE risk factors and receives a score based on their identified level of risk. Depending on the score, a physician order set prints and is placed on the medical record. The record includes the patient's total score, identified risk factors, and recommendations for appropriate DVT/PE prophylaxis.

"The information is available to the physician who looks at the risk factors and determines what is appropriate for the patient. It's driven by physician, but we give them the reminder to encourage them to order," George says.

The outcomes managers read current medical journals and guidelines to make sure their units are following the best practices.

"We look at benchmarks to see where we can make improvements. We are at the national average on many indicators, but we want to see if there are things we can do that will make us better. Our medical director says that if the hospital is losing money on a procedure, there must be inefficiencies or variation in practices. This shows us areas to look into," Jones says.

Sometimes a nurse or physician brings up an issue that spurs a project. For instance, the nurses on the cardiac unit reported that some patients were coming back from cardiac catheterization procedures with hematomas.

Jones and her team investigated the hematoma problem. "It was challenging to find articles and evidence-based practices on hematomas after a cardiac catheterization," she says.

The team looked at the amount of medication, the size of the patient, and other postoperative factors that could indicate a trend. They looked at physician practices and the closure devices used to see if one had a higher rate of complications than another.

The team found out that there was a difference in the types of closure device used in the cardiac catheterization lab and suggested that physicians consider changing.

Physicians have responded favorably to the outcomes managers and their projects, partly because the outcomes managers work with them to change processes in ways to make their lives easier, Jones says.

"Physicians respond to good data, and they respond to somebody who will help them change the processes that make their job more difficult. The outcomes managers have developed a close and trusting relationship with the physicians because they've worked with them on changing processes," Englert says.

*(Editor's note: For more information, contact **Jan Englert**, RN, at e-mail: jenglert@nmhs.net.)* ■

GUEST COLUMN

Is it time for case management redesign?

Redesign requires engagement of all stakeholders

By **Patrice Spath**, RHIT
Brown-Spath & Associates
Forest Grove, OR

The ever-increasing demands on case management services require a fresh new look at work practices. One way to do this is through a role redesign project. Role redesign is an improvement technique that involves looking at ways to improve the internal workings of the case management department to better meet the needs of the health

care team and patients. Role redesign is about making case management services better. The systems approach of role redesign requires engagement of all the stakeholders in planning, implementation, development, and evaluation. Role redesign is not a way of getting staff to do more for less, nor is it a cost-cutting exercise. It is a systematic technique for responding to a widening gap between case management service demand and delivery, which cannot be filled simply by hiring more staff. Think about employees in the case management department and the way work is done now. Do you feel that:

- People fully use all of their training and skills?
- There are enough staff to ensure accurate, timely and effective services?
- Staff roles are designed around customer needs?
- People effectively use all the technology available?

If you answered NO to any of these questions, then it may be time to redesign roles in the case management department.

Getting started

Your starting point for redesigning roles must be, "What needs to improve?" Begin by being specific about what you are trying to accomplish and turn a problem into an aim.

For example:

Problem: Insurance payment rejections are not communicated to case management in a timely manner, causing missed opportunities to respond by the deadline.

Aim: Improve timeliness of receipt of insurance payment rejections.

Next, determine the root cause of the problem. This is not always obvious, especially where current work practices are based on local customs or simply habit. To pinpoint the root of the problem, start by creating a description of the current situation and problem and then work backward to identify the cause. The steps below will help you focus on the root of the problem and discover how role redesign and other improvement ideas can help you find a solution.

1. Hold a meeting with the people involved in the process. Post lots of flip chart paper on the walls to give you plenty of room to work. Ask the group to consider the way things are done right now and the problem. Have the group answer questions, such as:

- What works well?
- Why does it work well?
- What has been troubling you about the problem, e.g., the way the reports are filed in records of discharged patients?
- What do you think is the problem?
- What have you tried in the past to fix this problem? Did it work? If not, why?
- What ideas do you have for improvement?

2. Write the problem on a Post-It Note and place it on a flip chart paper. Begin a detailed analysis of possible causes by asking WHY questions. Start with a question such as, "Why are coders waiting too long to get complete inpatient records?" There will be several possible answers to the starting question. Continue asking WHY for each of these answers. Ultimately, the group will arrive at the underlying or root causes of the problem.

3. Identify the people who have job roles linked to the root causes. Have the group consider how changes to existing staff roles or the development of a new role can help solve the root causes of the problem. It may be helpful to go back to the list of issues developed in step one. You should have a clear understanding of everyone's current job responsibilities and the current mix of skills. This information is useful for understanding the available resources in the department.

Dig into the process

Develop a flowchart of the current process to really understand what happens at each step and who is involved. But make sure that all employees feel involved and it is not just being "done to them." Once you have some data about who does what and how it affects the outcome of the process, get everyone together to look at what the data show.

Creative thinking is an essential part of role redesign. Give people permission to think differently and imagine the unimaginable. Then begin to talk about how things could be done differently, including expanding current roles or creating completely new ones. Encourage people to ask, "Why are we doing it this way?" Start making small changes and work up to the bigger ones. Small incremental change often is not as threatening to staff. Most likely, you'll need to make a persuasive case for redesigned roles, so gather as much evidence as possible to support the changes.

If a new role is to be added to the case management department, it may be necessary to persuade the organization's leaders to increase the

department's budget. To prepare for this eventuality, during the early stages of the role redesign project start building the business case for change. Infor-mation that should be included in the business case is listed below. If your organization has its own template, then of course you should use it.

• **Proposition or summary.** This is a two- to three-sentence statement of the change that is being proposed.

• **Context.** Provide two or three sentences about why the proposed change really matters to case management services and the organization.

• **Scale of change.** State how many new or amended roles you are proposing.

• **Financial analysis.**

— Detail the estimated costs split between:

☐ **Nonrecurring (one-time) costs:** project management, equipment, recruitment, initial training, evaluation, changes to accommodations, etc.

☐ **Continuing costs:** Salaries, etc.

— **Estimated savings.** If the proposed change will result in increased revenue for the hospital, provide an estimate of this increase. For many role redesigns, increased revenue is not the goal, and in these situations it may be difficult to quantify savings. But remember that you are looking at ways of doing things differently, not just adding extra staff. Look for savings in staff costs, such as reduced use of temporary staff, fewer complaints, less paperwork, etc.

— **Evidence and risk.** Here you should say why you believe the proposed change will work. Give examples of your small-scale test of the role redesign or history of successes in other organization. Also include potential risks and how you plan to prevent them.

In role redesign, individuals in the department or throughout the organization take on different case management-related tasks. This can be accomplished in several ways. A task can be moved down the skills ladder. An example would be moving the task of report filing to a clerk rather than having case managers perform this task. Tasks or individuals can be moved up the skills ladder, such as the case manager who takes on concurrent documentation enhancement responsibilities on the nursing units. The breadth of an existing role can be extended.

For example, data analysts can be trained to phone in patient information to insurance companies. Role redesign also can involve developing new roles that combine selected tasks normally done by a variety of traditional roles.

To help convert your role redesign ideas into practical working realities, start by taking a fresh look at problematic processes and functions in the case management department. Get everyone involved in identifying ways of changing roles or the way work is done to improve services and customer satisfaction. ■

Is Your Department a Candidate for Role Redesign?

Is role redesigning the right thing to do in your department? Think about your work team and respond to the questions below. The more questions you answer YES, the more likely that role redesign would be a worthwhile undertaking in your department.

	Yes	No
• Are you and your colleagues so busy that you feel you cannot stop to think?	___	___
• Do you and your colleagues get bored with the same repetitive tasks?	___	___
• Are you and your colleagues keen to learn new skills to enable you to offer better services to case management customers?	___	___
• Do you and your colleagues spontaneously offer to help each other out?	___	___
• Do you or your colleagues get frustrated because you could do more for case management customers but are prevented by time constraints?	___	___
• Do some staff members have time on their hands, yet others are very busy?	___	___
• Do your internal or external customers complain about the case management department's inability to meet their needs?	___	___
• Are clinically skilled professionals spending more time on routine clerical tasks than on handling tasks requiring their expertise?	___	___
• Do you feel that some of the services you provide could be provided more efficiently by another department?	___	___

Source: Brown-Spath & Associates, Forest Grove, OR.

ACCESS MANAGEMENT
QUARTERLY

Initiatives help cut write-offs, improve compliance

Case managers review charts daily

Through a series of case management initiatives, Methodist Medical Center in Oak Ridge, TN, has dramatically reduced its emergency department's Medicare write-offs and improved its compliance with core measures.

The Medicare write-offs have dropped from an average of $40,000 a month to less than $2,000 a month, reports **Coletta Manning**, RN, MHA, CPHQ, director of clinical effectiveness and quality improvement.

In the third quarter of 2005, emergency department physicians were 100% compliant with the core measures and would document when the recommended procedures were not appropriate for their patients, Manning adds.

The hospital has one full-time case manager and one part-time case manager who work in the emergency department and in same-day surgery, respectively.

The case managers go to the charts on a daily basis to make sure the core measures have been followed and that the procedures ordered for the patients meet medical necessity criteria.

Lisa Lane Byrd, RN, BSN, CCM, the full-time emergency department case manager, attributes the savings and compliance with the core measures to improved documentation by the emergency department clinicians, improved coding by the emergency department coders, and changes in routine treatment.

"When we first put a case manager into the emergency department, her objective was to work with physicians and make sure that they were documenting appropriately," Manning says.

The case management department examined the highest volume of procedures that were being written off and focused on those first.

For instance, when the initiative started, physicians routinely were ordering three sets of two different cardiac enzymes a few hours apart, for troponin-I and CPK, enzymes that indicate an acute myocardial infarction, on all cardiac patients.

"Medicare pays for one, but they were routinely doing three of each," Manning says.

When a literature review showed that ordering all of the tests was not necessary, Byrd met with the emergency department physicians and the hospital's cardiologists to determine if the routine procedures could be cut or eliminated without harming the patients.

"We no longer routinely draw CPKs in the ED, and we routinely draw only two troponin-I's. This has substantially decreased the monetary loss without compromising patient care," Byrd says.

ED physicians were ordering prothrombin times and partial thromboplastin times, tests to determine how fast blood coagulates, as routine workups for patients with a variety of conditions.

"Both are not always necessary. When we talked to the physicians at one of their monthly meetings, several physicians said they ordered them out of habit and had never thought about it being a reimbursement issue," Byrd says.

Now, the physicians are more selective about which patients get the tests, and they don't always order them together, she adds.

The emergency department case managers shadow the emergency department physicians, following them for a period of time, checking their documentation, and pointing out where they could make improvements.

"We tell them we don't expect them to keep up with all the criteria. It's constantly changing, and it's different with Medicare and commercial insurance. Most of the time, the doctors don't even know what type of insurance the patient has, and it's up to us to fill in the blanks," Manning says.

When the case managers started the project to shadow the physicians, Byrd brought it up at one of the monthly staff meetings.

"We told them we were looking at how to

improve documentation, to make sure patients met the medical necessity criteria for procedures, and to make sure that the core measures are being followed," Byrd says.

None of the physicians opposed the plan. In fact, some volunteered to be the first ones shadowed.

Byrd works in the ED Monday through Friday from 8 p.m. to 4:30 p.m. The ED doctors rotate on various shifts, and eventually she shadowed all of them. "When we first started, we targeted the ones that were struggling the most. The doctor who had the most write-offs asked me to help," she says.

When she shadows physicians, Byrd stays out of their way when they're seeing patients and reviews the charts behind them. She chats with the physician between patients, checking with him or her on documentation and keeping a running tally of what she accomplished each time.

"If I find somebody who is a core measure candidate, I put their patient identification sticker on my clipboard and check to make sure they received the recommended procedure and it was documented," she says.

When the emergency department case management initiative began, shadowing the physicians was a major area of focus. Now, the case managers shadow the physicians only occasionally, concentrating on other areas of concern.

"We've done a lot of work with the coding staff and the physicians. Sometimes the coders didn't code something in the chart because they didn't recognize what it was. We continue to work on improving coding on a daily basis," Manning says.

When the hospital's business office write-off program rejects an emergency department laboratory test, X-ray, or other procedure because of lack of medical necessity, the case managers are notified and review the chart.

If the necessary symptom or diagnosis is in the record but hasn't been coded, she notifies the emergency department coder, who adds them. If the physician hasn't documented medical necessity, the case manager asks the physician to review the chart and explain what symptom of diagnosis or clinical judgment prompted him or her to order the test.

CE *questions*

9. According to the Institute of Medicine, what is the cost of low health literacy each year?
   A. $100 million
   B. $58 billion
   C. $10 billion
   D. $850 million

10. When North Mississippi Medical Center began a project to ensure that patients received the recommended medications after a heart attack, the hospital's mortality rate was 15.3%. After six months, what was the mortality rate for heart attacks?
   A. 8.2%
   B. 6.5%
   C. 10.2%
   D. 12.8%

11. What is the average length of stay for joint replacement patients at the Sioux Valley Hospital USD Medical Center's Center for Joint Success?
   A. 5 days
   B. 6 days
   C. 4 days
   D. 3 days

12. After a series of case management initiatives in the emergency department at Methodist Medical Center in Oak Ridge, TN, Medicare write-offs dropped from an average of $40,000 a month to what average monthly figure?
   A. $2,000
   B. $10,000
   C. $30,000
   D. $7,500

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

"If the clinician is unable to add the symptoms or diagnoses, the test is written off and the deficiency is kept on file," Byrd adds.

Byrd creates a monthly report for each physician, comparing their write-offs and compliance with the core measures with other physicians, who are not identified by name.

COMING IN FUTURE MONTHS

- Why hospitalists and case managers should work as a team
- Strategies for caring for uninsured patients
- How one hospital coordinates care for short-stay cardiac patients
- Using telemedicine for follow-up care

"This created some competition. Everybody got very interested in ways to decrease the write-offs and improve core measures," Byrd says.

The case management team presents the Medicare write-offs and core measures compliance results each month at the emergency department's physician meeting.

If a physician has a month without a write-off or core measure deficiency, he or she is given an award, as part of the hospital's incentive program. The write-offs and incentive awards are considered during the re-credentialing process.

The emergency department case managers and inpatient case managers work together to identify deficiencies in meeting the core measures and to educate the staff. The inpatient case manager completes core measures forms for each appropriate patient, identifying whether the core measures goals have been met.

She notifies the emergency department case manager if the emergency department staff are involved. The ED case manager provides one-on-one education to the physician and notifies the appropriate emergency department shift manager, who counsels the nurse.

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 **June** 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. ■

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. ■

The case management staff post "friendly reminders" of the core measure goals and requirements in the emergency department, staff and physician break rooms, and nursing stations and compile monthly "core measure report cards" for each physician.

The case management department has worked hard to create a rapport with the emergency department staff, Manning says.

"We worked to show the emergency room doctors that the case managers aren't just the money police. We do a lot of things like find community resources for patients who are homeless or who can't pay for their drugs. We've even arranged nursing home placements direct from the ED," she reports.

Manning has hired a coder with a background as a coding instructor to help the physicians throughout the hospital understand what they need to document. She estimates that the coder has helped the hospital increase its revenue annually by $300,000 to $400,000.

In the same-day surgery arena, the case managers work with physicians and their office staff on criteria for inpatient admission.

For instance, Medicare specifies that some procedures are inpatient only. If they are done as same-day surgery, the hospital doesn't get paid. ■