HOSPITAL CASE MANAGEMENT™

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

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IN THIS ISSUE

Financial Disclosure:
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MAY 2006
VOL. 14, NO. 5 • (pages 65-80)

Case managers can take the lead in pay-for-performance initiatives

Proliferation of programs on the horizon

At some point in the not-too-distant future, your hospital's reimbursement is likely to hinge on its performance on quality measures, at least for some diagnoses.

"We're seeing that pay for performance works. We're seeing increased quality of care for patients, which will mean fewer costly complications — exactly what we should be paying for in Medicare," said **Mark B. McClellan**, MD, PhD, administrator of the Centers for Medicare & Medicaid Services (CMS), upon release of data from the CMS/Premier pay-for-performance Medicare demonstration project.

In that project, CMS has awarded $8.5 million to 123 hospitals that showed measurable improvements in care during the first year of the program. This is the first time that Medicare has awarded monetary bonuses to health care providers in a pay-for-performance demonstration. The results of the first year's performance were released late in 2005.

Under new rules that went into effect Oct. 1, 2005, CMS is taking an additional step toward implementing its pay-for-performance initiatives by giving the full 3.7% market basket (inflation-based) reimbursement increase only to hospitals that submit previously voluntary quality data, and only if the quality data meet accuracy standards for two consecutive quarters.

"One of the problems is that CMS has been getting inaccurate data. Once they begin receiving correct data for the core measures, they will add more performance measures to the list and ultimately move toward pay for performance for hospitals that meet quality targets," predicts **Teresa Fugate**, RN, BBA, CPHQ, CCM, a case manager with Crescent PPO in Asheville, NC.

"Pay for performance is a win-win situation for Medicare. If hospitals improve the quality of care for their patients, they're naturally going to decrease their costs," Fugate points out.

In addition, the Leapfrog Group, a Washington, DC-based organization focused on quality and safety initiatives, has rolled out its Hospital Rewards Program, which ranks hospitals in four tiers based on quality measures and resource use, allowing commercial insurers and employer groups to use the data for pay-for-performance initiatives.

"The idea behind pay for performance is mounting evidence that the quality and efficiency of health care varies tremendously from one institution to the next and even from one service line to the next within the same institutions. It doesn't make sense to pay all providers the same. The pay-for-performance concept is something that is going to last," says **Suzanne Delbanco**, CEO of the Leapfrog Group.

The trend toward pay for performance represents opportunities for case managers to take the lead in making sure that patients receive the recommended care and that performance measures are documented in the patient's medical record, Fugate says.

"Pay for performance is going to be a really big deal to the executive team, because reimbursement will be tied to how a hospital performs," says **Jan McNeilly**, RN, CPHQ, CPHE, principal for clinical advisor services at Premier. "If case managers don't get involved in their hospital's initiatives on the core measures and other performance improvement measures, they're losing out on a great opportunity for professional growth and development. They have an opportunity to be on the forefront, helping get the hospital geared up and ready to go."

Case managers are critical to a hospital's pay-for-performance initiatives because they are working with patient charts every day and conducting concurrent review based on standards of care. They are in a position to provide oversight to ensure that the core measures and other performance indicators are being met, Fugate adds.

Hospitals have systems in place for physicians to document that they followed the care recommendations, but physicians aren't accustomed to having to justify why they didn't satisfy a CMS requirement when the core measures aren't met, McNeilly points out.

"Until we have something in place, somebody needs to facilitate the process. In many hospitals, the case management department is expanding beyond discharge planning and utilization management to make sure that specific patient populations get the recommended care and flow correctly through the hospital," she adds.

In today's fast-paced hospital environment, it's hard for physicians and nurses to keep up with all of the key indicators that need to be provided for a particular patient. This puts case managers on the front line when it comes to ensuring that the hospital is doing well on the performance measures, Fugate adds.

"Case managers are in the charts every day, reviewing what is going on with the patients. They are responsible for coordinating the care

Hospital Case Management™ (ISSN# 1087-0652), including **Critical Path Network**™, is published monthly by Thomson American Health Consultants, 3525 Piedmont Road, N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Case Management**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6 Mon.-Thurs.; 8:30-4:30 Fri. EST. E-mail: ahc.customerservice@thomson.com. Web site: www.ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $469. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $78 each. (GST registration number R128870672.)

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Editorial Questions

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of the patient. Quality indicators should be part of this process," Fugate says.

Case managers should be careful to make sure that the services mandated in the quality indicators are not only provided but also are correctly documented in the patient record, she adds.

"The bottom line is to merge the clinical and financial and understand how improvement in quality of care can impact reimbursement," she says.

Know the key indicators and make sure they are being followed. Assist in prompting and issuing reminders to make sure that clinicians at your hospital are following the indicators. Make sure your hospital is monitoring the performance measurements concurrently, when deficits can be corrected, instead of retrospectively, after the patient has left the hospital. "If you collect data only retrospectively, you have lost the ability to intervene and affect the outcomes," she says. When you review the charts, make sure you have a sheet with a list of the indicators appropriate to that patient so you can check off which ones are being followed.

When your hospital's data are compiled, study them and come up with ways to improve compliance. "When there are deficits in compliance, the hospital should be doing something on the front end to improve. It's simple to educate the nurses, physicians, and other people who are responsible for making sure the performance indicators are carried out," Fugate says.

At INTEGRIS Rural Healthcare, an 11-hospital system based in Oklahoma City, case managers drive efforts to comply with the core measures, says **Denise Caram**, MS, CPUM, CPUR, director of support services.

The hospital system uses the data submitted quarterly to CMS and creates a color-coded dashboard showing each hospital's performance on each of the core measures. **(For details, see related article on p. 71.)**

"If we're not doing so well on one of the core measures, the case managers drill down, find the reason, and come up with ways to improve. When they review the charts for patients with pneumonia, congestive heart failure, or MI, they have a sheet that lists the appropriate care; and if it isn't being done, they check with the physician to find out why," she says.

The case managers can't be totally responsible for a hospital's performance, Fugate says.

"All the disciplines in the hospital — including physicians, nursing staff, and ancillary services — need to be educated about how the things they do every day can impact the hospital's reimbursement. Case managers are in key positions to help remind the clinicians of what they should be doing as they go through the process," she says.

If everyone in the hospital concentrates on meeting the quality initiatives, patient care will improve, and the hospital's reimbursement will go up, Fugate says.

In the meantime, the pay-for-performance initiatives are in the start-up phase, and many people in the hospital may not understand their importance, she says.

"It's a situation similar to what happened when CMS started its prospective payment system, and case managers had to help the physicians understand why they needed to meet the target length of stay for each DRG. Case managers are in a primary position to help remind the other disciplines of the importance of complying with the core measures and educating them about the quality-of-care indicators," she says.

Pay-for-performance scores improving

More than 250 hospitals are participating in the CMS/Premier pay-for-performance project, which began in October 2003. The three-year project concludes on September 30, 2006.

The initiative focuses on five clinical areas — acute myocardial infarction, pneumonia, coronary artery bypass graft, hip replacement, and knee replacement — and has a total of 30 quality measures. The hospitals performing in the top 10% for a given condition receive a 2% bonus in addition to their regular Medicare payments for that condition. Hospitals in the second 10% receive a 1% bonus.

Preliminary information from the second year of the program shows that scores are continuing to improve, with the poorest-performing hospitals improving the most, according to CMS.

The Leapfrog Group's Hospital Rewards Program, launched last summer, measures performance for quality and efficiency in five clinical areas: coronary artery bypass graft, percutaneous coronary intervention, acute myocardial infarction, community-acquired pneumonia, and deliveries/newborn care.

These five clinical areas represent 33% of commercial hospital admissions and 20% of the money spent by commercial payers, Delbanco says.

"This is the first national pay-for-performance program that rewards efficiency and effectiveness

through the use of national accepted and standard measures of performance. It was designed specifically to make use of the data the hospitals are already reporting, whenever possible," Delbanco says.

The Leapfrog Hospital Rewards project includes measures of quality endorsed by the National Quality Forum and that are being collected either through the Leapfrog Hospital Quality and Safety Survey or through the ORYX initiatives of the Joint Commission on Accreditation of Healthcare Organizations.

The data will be available on The Leapfrog Group's web site. ■

LTACHs offer opportunities for patient contact

Patients have intense needs, long lengths of stay

If you're looking for an opportunity to develop a close relationship with your patients and manage their care for weeks and months, rather than days, consider working at a long-term acute care hospital (LTACH), says **B.K. Kizziar**, RN, CCM, CLCP, owner of B.K. and Associates, a case management consulting and life care planning company in Southlake, TX.

"An LTACH is a wonderful opportunity for case managers who want to spend more time with their patients. It represents a big shift in the acute-care case management paradigm, where the average length of stay is three days. The short length of stay limits the opportunities case managers have to get to know their patients," Kizziar says.

In order to be certified by Medicare as an LTACH provider, a facility's average length of stay must be at least 25 days, which gives case managers an opportunity to affect outcomes and quality of care, she adds.

"In an LTACH, case managers have patients for a longer period of time. They have the opportunity to manage the cost of care and quality of care. Most importantly, they have an opportunity to develop a relationship with the patient and the family, to educate them and be an influence to help them make educated health care decisions. In an acute-care hospital, case managers do discharge planning or utilization review, but they don't have a lot of time to do true case management, and many patients don't need it," Kizziar says.

LTACHs have the same licensure as other hospitals, but they are not required to have an emergency department or an operating suite, Kizziar says — just a procedures room where minor procedures can be performed.

Patients in an LTACH are very sick. They may be ventilator patients who are having a difficult time being weaned, people with serious wounds that are not healing and are too severe to permit them to be discharged to a skilled nursing facility, or patients with chronic diseases and multiple comorbidities. Many won't be able to go home and will require placement in an alternative level of care, Kizziar points out.

"LTACHs represent a niche market for patients who otherwise would have to stay in the acute care hospital without funding or be inappropriately admitted to a skilled nursing facility," she says.

Many LTACH hospitals have adopted the long-time case management model for acute care hospitals, with nursing in charge of utilization review and social workers handling discharge planning, Kizziar says.

"The LTACH environment is fertile soil for development of a true case management program in a hospital setting," she says.

When she served as vice president of case management for an LTACH company, Kizziar set up case management programs for the company's hospitals.

Since becoming an independent consultant, she has worked with LTACH organizations to develop case management programs, educate case management staff, and assist with ongoing case management professional growth.

In an LTACH, each patient's care is coordinated by a team that develops a treatment plan, sets a target discharge date, and plans what has to be accomplished between admission and the potential discharge date. The objectives include immediate and long-term goals that will enable the patient to meet the discharge plan, she says.

"Case managers are truly managing the case, partnering with the physician in planning the treatment, and orchestrating the care," she says.

Most of the patients in an LTACH are covered by Medicare, which has a prospective payment system for LTACHs, Kizziar says.

"This means that management of length of stay and cost, along with quality of care, is essential.

This requires intensive case management. These case managers are much more involved in the financial aspects of care than those in an acute care setting," she says.

In an LTACH, case managers must carefully monitor length of stay, because the hospital will lose money if the length of stay is too long for that DRG; and it will also be penalized if the length of stay is too short, Kizziar points out.

"Length-of-stay management is important in an LTACH setting, but when a comprehensive case management program is in place, cost and length of stay take care of themselves because of the influence of the case manager," she says.

Case managers monitor the treatment plan, making sure it's appropriate for the patient and ensuring that the right treatment is given at the most opportune time for the patient to receive the most benefits.

They must ensure that the patient's care is both efficient and cost-effective. For instance, they must make sure that the results of diagnostic studies are in the chart and available so that costly procedures aren't repeated.

Much work with families required

Many patients admitted to an LTACH have so many issues that they can't be discharged to home. This means that case managers spend a lot of time working with families to find a discharge destination that will work for the patient, Kizziar points out. For instance, LTACH case managers are challenged to find a discharge destination for ventilator-dependent patients and those who require dialysis. Many skilled nursing facilities won't accept these types of patients because they won't be reimbursed for their care.

"Difficult discharges are something an LTACH case manager faces every day. The majority of these patients have serious illnesses with multiple comorbidities, and many cannot go home," she says.

When a patient is to be discharged to home, the case managers work with community agencies to make sure all the resources the patient needs are in place at discharge. These resources include everything from transportation to meals to spiritual support, she says.

Case managers in an LTACH setting often provide disease management, working with patients and family members on managing chronic and comorbid conditions so the patient can avoid being readmitted to an acute care hospital, she says.

There's not a cookie-cutter type of case management program that will fit every LTACH, Kizziar says.

"Each hospital has its own culture that has to be taken into consideration when a case management program is developed. While the principles of case management don't change according to the environment in which it's being carried out, the way in which case managers practice is affected by the environment in which they work," she says.

Lower CM-to-patient ratio

The case-manager-to-patient ratio depends on the program's objectives, the severity of the patients' illnesses and injuries, and the skills and abilities of the case managers, Kizziar says.

"One case manager to 15 patients is a guideline, but it may be more or less," she says.

"Patients in an LTACH do have intense needs. Case managers have to monitor the treatment plan at all levels, be familiar with community resources, conduct patient and family education, and take care of everything that's needed for the patient at this level of care and after discharge. I don't think it is possible for even an experienced case manager to provide all the services necessary for these patients and manage the care of more than 20 patients," she says.

Based on her experience with LTACHs, Kizziar recommends that the same case manager handle both utilization review and discharge planning.

"Case management as a whole encompasses both of these areas, and case managers should be doing both. Social workers are important in an LTACH environment because of family issues, education, and community needs; but rather than fragment discharge planning and utilization review, I suggest that the case manager handle both tasks and utilize social services as a professional consultant whenever it's necessary," she says.

The idea of a long-term care hospital for patients with acute medical needs is nothing new, but there has been a proliferation of LTACHs in recent years, especially along the Northeast coast and across the South. For instance, there are more than 10 LTACHs in the Dallas-Fort Worth area alone, Kizziar says.

While a few LTACHs are operated by acute care hospitals, the majority are operated by LTACH companies, either in freestanding buildings or in space leased out from an acute care hospital and separately licensed, she says. ■

Following CF patients throughout continuum

Multidisciplinary team provides treatment, support

A case management program that follows adults with cystic fibrosis (CF) through the continuum of care has paid off for Dartmouth-Hitchcock Medical Center in Lebanon, NH.

The CF program at the academic medical center is ranked in the top 10% in quality measures among Cystic Fibrosis Foundation-accredited centers.

Priscilla Robichaud, RN, CCM, continuing care manager-pulmonary, manages the care of 75 cystic fibrosis patients, seeing them in the clinic with the pulmonologist, coordinating their treatment while they are in the hospital, visiting them in the home whenever possible, and keeping in constant touch by telephone and e-mail.

"I've been working with these patients for nine years, and I've become part of their family. At the medical center, I've become the person who knows everything about those patients, and I'm the filter for all of the issues the patient has," Robichaud says.

Robichaud was part of a group of advanced care managers hired to coordinate the care of patients in the medical center's outpatient clinics. She was hired originally to manage the care of CF patients in the clinics, but as her expertise increased and her rapport with the patients grew, her role expanded to the hospital bedside.

Initially, a different case manager worked with the CF patients when they were admitted to the hospital, but the patient would just tell that case manager: "Ask Priscilla. She knows everything about me."

"I have become the advocate for these patients," Robichaud says. "The most rewarding part is seeing them in the community continuum. I do home visits as often as possible, see them in the clinic, and manage their care when they're inpatients."

When she started the assignment, Robichaud began seeing patients in the clinic treatment room with the provider so she could learn more about the disease and its effect on the patients, a practice she continues today.

"These patients are so consumed with the physical, emotional, and financial toll the disease takes that it's hard to separate the issues. When a doctor starts patients on a new medication and they aren't sure their insurance company will pay for it, I'm there to help them," she says.

People with CF often have issues with insurance, medication, emotional problems, and compliance with their treatment plan. "These patients are very well educated about their disease but are not always as adherent to their treatment plan as we would like," Robichaud says. "I try to educate them on how adhering to their treatment regime will help them avoid problems down the road."

Robichaud manages the care of patients ages 18 to 67. The average life span of people with CF is 35 years, but she has a number of patients in their 40s and 50s. She also manages the care of patients at an outpatient clinic for the amyotrophic lateral sclerosis population.

At the clinic level, Robichaud is part of a multidisciplinary team that includes a pulmonologist, a physical therapist, a respiratory therapist, a nutritionist, and a social worker. Robichaud accompanies the pulmonologist when he sees patients in the treatment room.

During the clinic sessions, other members of the team see the patients separately. Team members record what they discuss with the patient on a computer, including changes in treatment plans and other recommendations. When the patients leave, they receive a copy of the combined clinic notes made by Robichaud and the pulmonologist.

The team holds a separate clinic for patients with CF-acquired diabetes, adding an endocrinologist and a diabetes nurse to the team.

About half of the patients are hospitalized at least once or twice a year and lead active lives the rest of the time. Their average length of stay is four to five days. A few patients are in and out of the hospital frequently.

Because of her long involvement with her patients and her in-depth knowledge of their conditions, Robichaud often is able to negotiate with insurance companies to extend the length of stay when she thinks it's necessary.

"We've been challenged by insurance companies on only two admissions, and we won both on appeal," she says.

In between visits to the clinic and hospital, Robichaud's patients contact her frequently by telephone or e-mail.

"I do a lot more work on the telephone than I ever thought I would. It comes with experience in knowing the disease and the patients. The patients look to me to be their advocate," she says.

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Dashboard helps hospitals focus on core measures

Green, yellow, red designate performance

A color-coded performance-tracking dashboard posted in strategic locations helps clinicians at INTEGRIS Rural Health's hospitals stay focused on the core measures of the Centers for Medicare & Medicaid Services (CMS).

The dashboard is created quarterly, using data that are sent to CMS. It lists each individual measure, with the hospital's performance on that measure represented by a color code, says **Denise Caram**, MS, CPUM, CPUR, director of support services for the Oklahoma City-based eight-hospital system.

"It shows me by hospital and by system how well we are doing," Caram says. "If a hospital is doing well on that particular measure, it's green; if a little improvement is needed, it's yellow; if they need a lot of improvement, it's red."

The case managers are deeply involved in improving performance on the core measures, Caram says.

When the hospital system first looked at compliance with the core measure targets, the administrators drilled down to find out why some hospitals did well and others did not do so well.

"In the hospitals that were very successful at meeting the core measures, the case managers were heavily involved in compliance activities. It was an eye-opener for all of us," Caram says.

When the hospital system implemented its physician-aligned case management model in early 2000, the case managers worked with physicians to develop order sets for the top DRGs, based on evidence-based guidelines.

Those order sets became a guide for case managers who review the patient chart and make sure the recommended care is followed and documented. For instance, the order sets required that pneumonia patients receive antibiotics within two hours of admission.

The process paved the way for the hospital system's compliance efforts when CMS implemented the core measures performance measurement system.

The corporate quality department developed the dashboard as a way to easily demonstrate how each hospital is doing on each of the core measures and how the system is performing overall. The case managers are closely involved in gathering the information.

"Each quarter, the dashboard makes it easy for people to know where to focus," she adds.

The dashboard is posted in prominent places around the hospital and on INTEGRIS Healthcare's web site.

"If the hospital isn't 100% compliant, this gives them an indication of where things need to improve. They can go back and do a chart review and drill down to find the reasons," she says.

When they review the charts, the case managers use a "cheat sheet" listing recognized standards of care for each DRG. They check to make sure that everything indicated for the patient has been done and has been documented in the chart. If the care mandated on the order set for that DRG isn't being implemented, the case manager checks with the attending physician to find out why.

The hospital system's administration takes compliance with the core measures seriously, Caram says.

"The dashboard is driven by the quality director in each facility, and they have had an excellent partnership with the case management department. Even when change is hard, we all have to be change agents. At our hospital system, it's been a continuous learning process, with all disciplines involved," she adds. ■

Balanced scorecard helps CMs focus on improvement

Charts show trends in LOS, charges, readmissions

A balanced scorecard showing case mix, length of stay, charges per case, and other data on a monthly and quarterly basis helps the case managers at INTEGRIS Rural Health focus on areas where their hospital needs to improve.

"The balanced scorecard shows the big picture of how hospitals in the system are performing and how individual physicians and case managers are performing. It shows trends in our length of stay and charges per case, but there's a lot more information than that. It ties in with our quality initiatives, the core measures, and what we need to be doing to get ready for the next Joint Commission on Accreditation of Healthcare Organizations [JCAHO] survey," says **Denise Caram**, MS, CPUM, CPUR, director of support services for INTEGRIS Rural Health, an 11-hospital system based in Oklahoma City.

The balanced scorecard shows data for all patients, with data for Medicare/Medicaid patients broken out separately. In rural Oklahoma, a high percentage of patients are Medicare or Medicaid beneficiaries, Caram says.

The information on the balanced scorecard is compiled from medical records data that each hospital sends to the corporate office. Caram's assistant downloads the information, puts it into the balanced scorecard format, and sends it to Caram, who passes the information on to all of the hospitals.

"Each hospital is totally different, but seeing the data from the other hospitals gives them an idea of how they are performing in comparison to the rest of the system," she says.

The balanced scorecard helps Caram keep a close eye on the performance of the case management departments at the 11 rural hospitals scattered across Oklahoma, many of which have only one case manager.

The hospital system started out creating a balanced scorecard only for Medicare patients, then expanded it to track all patients. Medicaid patients were added in April 2006.

At INTEGRIS, the case managers report to the chief financial officer.

"I felt like the CFO would be more likely to take the case management activities seriously because it affects the bottom line. In addition, the CFOs and administrators have a better understanding of the case management process, not only from the clinical side, but they also get to know the practice patterns of our physicians as well," she says.

The scorecard for each hospital shows trends over the past year broken out by quarters, including the overall med/surg length of stay, overall med/surg charges per case, and case-mix-adjusted med/surg charges per case. The data are broken out by all patients, Medicare patients, and Medicaid patients.

It also includes the indexed length of stay, which shows whether the length of stay for patients in the hospital's diagnoses mix is within the guidelines for commercially insured patients or the geometric mean length of stay for Medicare patients.

"The indexed length of stay looks at length of stay as well as case mix. It shows us whether patients are going home too soon or if we are keeping them beyond the geometric length of stay for that DRG. If the indexed length of stay is too low, the hospital may have an increase in readmissions. When a hospital has a lower length of stay, it's not necessarily an indication of quality, especially if the case mix is up," she points out.

The balanced scorecard breaks out data for the top-volume med/surg DRGs, tracking trends in the geometric mean length of stay and charges per case over a one-year period.

It shows Medicare coding efficiency, physician-specific indexed length of stay, and case manager-specific length of stay for med/surg DRGs, and it shows readmission rates within 30 days for top-volume med/surg DRGs.

Caram looks at each hospital's balanced scorecard monthly. After reviewing the data, she e-mails the local case manager to point out areas where improvement is needed and to suggest what might be done to improve.

For instance, if the length of stay is particularly high for a given DRG, she suggests that the case manager look at the hospital's charts and determine whether there is a specific physician who is driving the high length of stay. The hospital system uses a physician-aligned model of case management and has developed standard order sets for the top DRGs.

"Each hospital can look at the balanced scorecard and see if there is a physician who isn't following the hospital's order sets or who frequently has patients whose length of stay exceed the norm," she says.

Recently, one hospital's data showed that the patients of 11 doctors had lengths of stay that exceeded the norm. Caram e-mailed the CFO and the case manager to make sure they were doing something to correct the problem.

"It's a collaborative effort. I'm not berating them. I just point out areas where they need to focus their improvement initiatives," she says.

For instance, if the data show that the charges per case are too high for a particular DRG, the case manager looks further to find out which physicians are responsible for the overutilization.

"We have begun to look at the quality side. If we are having a lot of readmissions, we look at why. We drill down to the individual physician and take our data to the medical staff," she says.

Caram and the case managers present the scorecard to the local hospital boards on a quarterly basis, share it with the medical staff, and use it in utilization management activities.

"When we have our quarterly administrative team meeting at each hospital, the administrator and the CFO come prepared to tell us why the length of stay is up or why they are having an increase in readmissions. One facility that wasn't doing so well has started turning around since they have seen the data. The balanced scorecard shows them why they need to change," she says.

When the case management activities were first standardized across the hospital system, Caram instituted quarterly educational sessions, bringing all the case managers together to share patient strategies, discuss changes in Medicare and other reimbursement, and learn from each.

"These case managers had a clinical background but not a financial background. They didn't realize the impact their department could have on the hospital. Initially, I had to do a lot of teaching on the financial side," she says.

Now the meetings are held twice a year, and Caram is planning a retreat for the case managers that will include an expert speaker to discuss where case management needs to go in the future.

Caram talks to the case managers at each hospital twice a week, on Monday and Thursday.

"On Monday, we discuss the census and where we're going. On Thursday, we discuss how we can get patients who are nearly ready for discharge out before the weekend," she says.

If a patient has been in the hospital for six days on Thursday and the case manager doesn't get him or her discharged before the weekend, the patient will have been in the hospital for 10 days by the time Monday rolls around, Caram points out.

"We're not trying to push them out if they're sick, but it's good to have a discussion," she says.

For instance, nursing home admissions on the weekend tend to be a problem, causing delays in discharging the patient from the hospital.

To alleviate the problem, one case manager has built a relationship with a local nursing home that now will take patients on the weekend.

All the rural hospitals received a grant from the INASMUCH Foundation, a state-level nonprofit organization based in Oklahoma City, to provide additional money for patients who may need assistance with medication, transportation, education, equipment, and other needs.

"This in turn has generated enthusiasm for the hospitals to do some fundraising," she says.

The case managers screen the patients before helping them with medication. If the patient comes to them several times, the case manager offers to pay part of the cost of the medication if the patient will pay the rest.

"Making sure that patients get their medications is a good way to keep them from being hospitalized again," she says. ■

Comply with JCAHO's goal to label all medications

Many organizations are not in compliance

The Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) National Patient Safety Goal requiring all medications to be labeled sounds simple enough, but it's proving to be difficult for many organizations.

"I think the biggest challenges for an organization center around the back-table labeling of syringes and containers," says **Susan Mellott**, PhD, RN, CLNC, CPHQ, FNAHQ, who is CEO of Houston-based Mellott & Associates. "While the operative areas may be already doing this, this has not always been occurring outside of those areas."

Even within the operative areas, staff may not have been labeling syringes or basins that contain normal saline or other "non-medication" fluids, says Mellott. "I am sure that a clarification will be coming out stating that any procedure area will have to comply with this goal. If there is not such a clarification at this time, organizations would

be well advised to implement this goal in the non-perioperative settings, as it is really best practice," she says.

Newly revised requirements for the safety goal have been changed to make them more consistent with the requirements in Medication Management standard MM 4.30. The new requirements are as follows:

- Labels include drug name, strength, amount (if not apparent from the container), expiration date when not used within 24 hours, and expiration time when expiration occurs in less than 24 hours.
- All labels are verified both verbally and visually by two qualified individuals when the person preparing the medication is not the person administering the medication.

The revision deletes a previous requirement to include on the label the initials of the person preparing the medication or solution and the date of preparation. Neither of these items is required under MM 4.30. After review by the Sentinel Event Advisory Group, it was determined that the deleted requirements provided "no additional safety to the preparation and labeling process," according to a JCAHO announcement.

Inventory the types of fluids and medications used during procedures, and then obtain preprinted labels for these solutions, recommends Mellott. "There could be a standard set for the facility and specialty labels for areas that require more labels than the common ones, such as the cardiac catheterization lab," she says. "The organization should then monitor for compliance after implementation." ■

Report: A growing 'quality chasm' for hospitals

Mortality rates are 27% lower

A new study from HealthGrades, a Golden, CO-based health care ratings company, names the top 5% of hospitals in the country — and also shows that this group has mortality rates that are 27% lower than other hospitals, with a 14% lower risk of complications.

The researchers analyzed 39 million hospitalization records at 5,122 hospitals over a three-year period, for 26 medical procedures and diagnoses.

The findings are strong evidence of the growing "quality chasm" between the nation's best hospitals and others, explains **Jeff Goldstein**, MD, senior consultant with HealthGrades' hospital quality assessment and improvement group. "We are seeing a widening gap between hospitals doing well and those hospitals who are not doing well," he says.

To qualify for the top 5% list, hospitals were required to meet minimum thresholds in terms of patient volumes, quality ratings, and range of services provided. Before comparing the mortality and complication rates of the nation's hospitals, data were risk-adjusted so that hospitals that treated sicker patients would be on equal footing with those that treated healthier patients. Hospitals with risk-adjusted mortality and complication rates that scored in the top 5% or better nationally were then recognized as Distinguished Hospitals for Clinical Excellence.

"These are difficult goals to achieve, because they require a big commitment from the hospital. There has to be a top-down solution, with a true leadership imperative. This can't be done with one department or service line; it has to be systemwide," says Goldstein.

As an example of this, Goldstein points to the RACE (Reperfusion of Acute myocardial infarction in Carolina Emergency departments) consortium, a group of North Carolina hospitals working to improve outcomes for patients with coronary disease throughout the continuum of care. "Patient care literally starts even before they walk in the door," he says.

Quality requires a significant amount of resources and is "more than just paint and plaster in the hallways," says Goldstein. "But this is an investment any industry would have to make."

Researchers concluded that 152,966 lives could have been saved and 21,896 complications could have been avoided if the quality of care at all hospitals had matched the level of those in the top 5% during the three-year study period. Armed with this type of information, consumers are playing a much bigger role in the health care decision-making process — not just patients but also their family members and employers, says Goldstein.

"People want to be certain they are getting the best possible outcome and the most value for their dollar," he says. "No one wants to go to a hospital that is not performing well. Any hospital administrator who is not sensitive to this fact is being very shortsighted. The more information the consumer has, the better off everyone will be." (To see the report, go to www.healthgrades.com.) ■

(Continued from page 70)

Robichaud makes an effort to visit her patients in their homes as often as she can.

"If we go into the home, we can prevent problems because we see what the home is like," she says. She notes that CF is a disease of malnutrition because it impedes the body's ability to absorb food. "We can look at what kind of food is in the refrigerator, and we can make sure they are doing therapy," she says.

"Seeing our patients in the home is a positive experience. Before I get to know them well, they're more likely to talk frankly and on a personal basis in the home as opposed to in the clinic. They know you're there because you're interested in them," she says.

Robichaud works closely with the hospital's social worker to see that the patients get the services they need at the clinic and hospital. For instance, patients may call her to say their car won't start and they have to get to a clinic appointment or that they've run out of money for food.

Often, the co-pay for the nebulized antibiotics that patients need is high, putting a strain on the family's budget.

"These patients are on multiple medications, they have a lot of psychological issues, and they need to follow a proper diet in order to avoid exacerbations of their disease," she says.

Dental care is another issue, because a tooth or mouth infection can spread into their bloodstream and their lungs. Many CF patients are on Medicaid, and few dentists will take them.

When her CF patients become eligible for a bilateral lung transplant, Robichaud coordinates their care with the hospital where the surgery is performed.

The clinic sees each patient a minimum of four times a year, but many are in touch with Robichaud by telephone or e-mail on a weekly or even daily basis.

"They know to call if they have a cold because it can develop into an infection. I talk to them about what treatment they should do at home and make sure they have the prescriptions they need," she says.

When a patient calls Robichaud because he or she has a cold or a fever, she talks with the patient about the symptoms and decides whether the patient should be seen in the clinic.

"We discuss what they can do for therapy at home, such as using nebulized antibiotics, as a way to avoid them coming into the hospital," she says.

Patients with an advanced disease state have ports that allow them to self-administer IV antibiotics at home. "Some are so experienced that we feel they can get as good care at home as they could get in the hospital," she says.

Because many of the patients are depressed due to their chronic disease, Robichaud also works closely with the social worker.

Lately, Robichaud has been working with the CF patient and family advisory group, created to work with the clinical staff on ways to improve care for the patients.

"We are asking our patients and family members what they think about the care they're getting and how they think it can be improved. They're part of every decision. I think both sides have learned a great deal," she says.

The group was successful in getting the New Hampshire legislature to develop a protocol for genetic testing for CF.

Advisory group addresses infection control

The patient and family advisory committee is looking at the Dartmouth-Hitchcock Medical Center's CF infection control policy, developed with the help of the Cystic Fibrosis Foundation.

"There is a bacterial infection that affects only CF patients. We can pass this bacteria from one patient to another just by having it on our clothes. It's a very aggressive infection, and we feel that the only way to prevent cross-contamination is for everyone in the clinic and inpatient hospital to put on gowns and gloves when they see patients," she says.

When the infection control initiative was begun, hospitalized patients felt that some staff members weren't coming to their rooms as often because it took time to put on gowns and gloves. Others were coming in without gowns and gloves on.

"The patients were brought into the process, and they have talked to the staff about the importance of wearing gowns and gloves. There have been outbreaks at other hospitals, but we haven't had any problem," she says.

The advisory committee worked with the clinicians on an educational program to make sure patients clean their nebulizers thoroughly in order to avoid infections.

"We discovered that only one of our patients really understood the infection control guidelines for nebulizers. After a year-long project, we've brought it up to 84%," she says.

The project was so successful that other programs across the country have adopted it. ■

ACCESS MANAGEMENT
QUARTERLY

Use technology, creativity to tackle ED overcrowding

Tracking system, good use of data provide answers

With a recent study highlighting the lack of surge capacity in the nation's emergency departments (EDs) and concerns about how health care facilities would respond in the event of pandemic flu, it's imperative that hospitals find meaningful patient throughput solutions, says **James Bryant**, director of emergency and transport services at Wake Forest University Baptist Medical Center in Winston-Salem, NC.

The American College of Emergency Physicians' (ACEP) "National Report Card on the State of Emergency Medicine," which gave the emergency medicine system of the United States as a whole a grade of C-minus, was "a wake-up call for the national health system," Bryant adds. "This is a challenge to make our system more flexible."

At least part of the response to that challenge lies in technological innovations, such as ED tracking systems that identify where patients are in the process and where the bottlenecks are, he says. With hospitals that have such systems, Bryant notes, the question becomes, "How are they using those data?"

Wake Forest put an electronic tracking system in its ED two years ago and began to see, among other things, that patients who had been triaged were sitting in the waiting room even though there were empty beds in the treatment area, he says.

"If there is a ready bed, patients should move directly from triage to the ready bed," Bryant says. "Putting them in the waiting room for 10 minutes just causes delay. That was the way we'd always done it, but it's not a good model. If you've got a bed, put the patient in it."

With the tracking system, everyone on staff sees the same information, he says. In the past, Bryant adds, the triage nurse might not have known what was happening in the back, and the charge nurse might have been unaware of the situation in the waiting room.

"If I don't know there are 15 people waiting to be seen, I may not be in as much of a hurry," he points out. On the other hand, if the charge nurse is aware of that crunch, and she sees that a person is waiting for discharge, Bryant notes, "she realizes that if she just goes over and [discharges the patient], she could have a ready bed."

Even newer technology — now in place at only a handful of facilities — would allow hospital staff to place transmitters on patients that would allow staff to look at a screen and know exactly how patients are moving through the department, he says.

The patient-tracking system, which uses radio frequency identification (RFID) bracelets, is similar to the technology used by the retail industry to create automatic inventory tags, Bryant notes. "Price is still prohibitive, but we're looking at the technology."

Patients wearing RFID bracelets, he adds, can be greeted by name, for example, as they approach the imaging area: "Hello, Mrs. Jones. We were expecting you."

"Bar codes are really popular, and this is the next evolution of bar codes," Bryant explains. "Patients would still get a bar-coded armband, but they would also have an RFID band."

In terms of patient safety, he adds, there would also be RFID tags on blood and medication, so that any mix-ups would be flagged.

ED diversions 'a symptom of the problem'

The ACEP report points out in its listing of national emergency care concerns that only 10 states currently collect data on the frequency with which hospitals go on diversion status, which is when hospitals "divert" ambulances because they are unable to handle any more emergency patients.

While diversion information is "very important," Bryant says, "hospitals are starting to catch

on that if hospital A goes on diversion, hospital B almost has to go on diversion, and so on; it just shifts the burden."

Wake Forest has a "no diversion" policy, he adds, partly because it is a Level I trauma center.

"Each hospital has to learn how to respond to its surge," Bryant says. "Diversion is a symptom of the problem." The report, he says, makes note of the need for surge capacity in the critical time between when a disaster occurs and when state or federal resources can be mobilized to respond. That need was highlighted by the Hurricane Katrina disaster.

The Joint Commission on Accreditation of Healthcare Organizations has recognized the situation as "more than just an ED problem," Bryant notes, and has instituted standards requiring hospitals to have a plan in place to address patient flow.

At Wake Forest, where an ED designed for 56,000 visits a year is accommodating 76,000, an ED holding unit is helping facilitate patient flow, Bryant says.

"Part of the rationale is that many patients are here for several hours just because of certain testing procedures, so we created a 10-bed holding unit on the sixth floor," he explains. "If patients are going to be [in the ED] for multiple hours, we move them there so we can bring in more acute patients."

The effort has been successful enough, Bryant notes. Plans are in place to expand the hours of the holding unit from 12 hours a day, six days a week to 24-7, probably in January 2007.

"It's been a real positive," he says. "It also offers more opportunities for the ED staff. If you're an ED nurse, the holding unit can be a little bit of a break. We can float staff, so it's a big staff satisfier."

'Quick reg' key to improvements

Innovations on the front end of Wake Forest's ED operations also have proved helpful in enhancing patient flow, Bryant says. After patient satisfaction surveys showed that people were dissatisfied because they felt they were not acknowledged upon their arrival in the ED, the hospital took another cue from the retail business.

"We put in a patient greeter who takes the patients' names [immediately] and puts them into the system, along with the complaints," he explains. "The triage nurse looks at the screen, sees the complaints, and takes the most urgent

CE *questions*

17. How much did CMS pay to hospitals that did well in the first year of its pay-for-performance demonstration project?
A. $5.6 million
B. $8.5 million
C. $10 million
D. $4.3 million

18. At INTEGRIS Rural Health, case managers report directly to the chief financial officer.
A. True
B. False

19. How long must a facility's average length of stay be for CMS to certify that facility as a long-term acute care hospital (LTACH)?
A. 10 days
B. 15 days
C. 25 days
D. 30 days

20. At Dartmouth-Hitchcock Medical Center, one case manager coordinates the care of how many cystic fibrosis patients from the clinic to the hospital and into the community?
A. 150
B. 40
C. 90
D. 75

Answer key: 17. B; 18. A; 19. C; 20. D.

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. ■

first. Initially our goal was for the patient to see the triage nurse within 15 minutes of arrival, but now we've gotten it down to four minutes or less. We were able to use the data created by the greeter, which include how long the person has been waiting."

Again, those data also are seen by the charge nurse, who can send someone out to help if she sees that five people have come in at once, he adds.

Before the greeter position was created, patients checked in at the central registration desk before going back for treatment, notes **Charlynne Lynch**, CAM, manager for ED registration/financial counseling.

"[The greeter] has certainly expedited the process, because [patients] no longer have to wait on us," she says. "In the past, if the triage nurse was busy, there was no one there to greet the patient and no coordination at the front desk."

The patient greeter is in place around the clock and reports to the nursing department, Lynch adds, although there has been some discussion of switching the position to the registration department.

The greeter, she says, goes into the admission/discharge/transfer system and does a "quick registration," starting with a patient name search in which the greeter enters the patient's last name, first name, and middle name, and asks to see a Social Security card or driver's license for identification.

If the search does not locate a medical record for the patient, Lynch notes, the greeter asks for the person's date of birth in order to create a new record.

Registrars verify admissions info later

Additional elements that may be entered (but don't have to be) during the "quick reg" are gender, race, mode of arrival, attending physician, and patient location, as well as designations for ED, pediatric ED, or "fast track," a lower-acuity area that is open from 11 a.m. to 11 p.m.

Registrars look at the registration later, after patient care has been initiated, and they verify all the components, Lynch adds.

ED "quick reg," an innovation that came about around the same time the electronic tracking system was implemented, got its start when ED staff and leadership were looking at a way to get patients on the tracking board without having to wait on registration, she explains.

"There are only a few registrars [to go around], but we have nurses or other clinical staff who are with the patient pretty fast," Lynch says. "Even one of the physicians said we don't have to have a [registrar] to be there immediately at all the beds."

Although she personally wrestled with the idea of relinquishing control of this piece of the registration process to clinical staff, the results speak for themselves: "It works," Lynch says.

She says access colleagues have asked her, "How comfortable are you giving that authority to nurses? Aren't you worried about duplicate medical record numbers?"

While she did have concerns about duplicates, Lynch explains, she was confident in the ED leadership's commitment to accuracy. "They also don't want any adverse effects. They've done an excellent job, and it's noticeable to us as staff members that the flow is much quicker. Now the patients are rapidly put in the system, so the information is captured as soon as they get there. Even in the back, if the patient comes in by ambulance, the nurse does the quick registration. We gave [nurses] the capability to do what we used to do. Now they're not waiting on registration at all. We're not in that flow, although we are definitely the support system."

The medical records department worked with registration staff in training both nurses and unit secretaries to do the quick registration, Lynch notes. "We modified our Healthquest system, a McKesson product, to allow the search for a medical record number to happen on a 'quick reg,' and to include only the fields that concern the clinical staff. If the nurses do select a good medical record number, they don't have to go through the patient name fields. [The system] will go straight to the fields they need to complete. It's not requiring them to do everything a registrar would do."

The one exception to the ED quick registration process is that trauma patients still are registered by her department, Lynch says. Registration typically receives a call in advance of a trauma patient's arrival, she says; but even if a patient is already in the ED and then is upgraded to trauma status, registrars are still notified, and they handle the registration.

"We have trauma packs with new medical record numbers," she adds. "We coordinate the trauma packs, and we maintain a log for trauma registry. We want everything at the bedside when those patients arrive." ■

Assess patient flow; use data to improve

That's JCAHO director's advice

The patient flow standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are "about planning," says **Carol Gilhooley**, director, survey methods development, in the division of standards and survey methods for the Oakbrook Terrace, IL-based agency.

"What we ask organizations to do is assess the flow from admit to discharge, collect data, analyze that data, and turn it into information that can be used to improve performance," Gilhooley adds. "Organizations need to step back and look at [ED overcrowding] as a hospitalwide problem."

Problems with wait time "could be a problem in the ED, but it might be because of slow discharge and because surgery and the ED are competing for those beds," she explains.

JCAHO suggests collecting indicators for key support services to help identify solutions that might not be immediately obvious, Gilhooley says. "Housekeeping may not be turning around rooms fast enough, or lab values may not be coming back quickly. It could be patient transport. Maybe it's the staffing in the admitting department. It's really an input/throughput/output situation. Match output to input, or otherwise there is a bottleneck. So look at the bottleneck and see what you find out."

Another important factor to consider when examining patient-flow issues is that once the decision has been made to admit an ED patient, that individual is defined as an inpatient, says Gilhooley. At that point, "all assessment and care protocols for inpatients are applicable. Say the person [waiting for a bed] is supposed to be admitted to the intensive care unit. Do they have access to the same technology if they're on a cart in the hallway? Do they have privacy? Access to a call bell? Is the appropriate physician — perhaps a specialist — available to care for that patient?"

JCAHO also expects the hospital to plan for the care of "borders": patients who are waiting for treatment, for diagnostic results, or to see a specialist, Gilhooley says. "Those kinds of individuals can add to a bottleneck situation."

A subject JCAHO surveyors are likely to address with hospital leadership is whether resources are provided to manage those patients, she says. A point to note would be, "Does leadership take action based on those data?"

While JCAHO's focus has always been to protect the quality and safety of care, the agency is now spending more time on the scene observing, Gilhooley says. "Before 2004, we spent a significant amount of time on policies and procedures, which were the promise of execution. Now we're looking at whether the promise is really implemented."

Since Sept. 11, 2001, emergency management has been particularly important, she adds. For example, surveyors might ask any hospital employee such questions as, "What do you do? Who do you report to? What are your responsibilities when the [hospital] implements its emergency management plan? How were you trained?"

A likely question for access staff, Gilhooley says, is "What do you do when the systems are down?"

"Our standards require two drills a year," she notes. "One is a drill when there is an influx of patients. I think [surveyors] might ask, 'Do you use temporary registration procedures? Do you have temporary triage areas and procedures?'"

Surveyors may select a scenario and ask a staff member to pretend that the hospital has just experienced that event, Gilhooley adds. "[The surveyor] may go to all the areas that would be impacted and say, 'Do you know what to do?'"

The whole process involved in the transition from paper to electronic medical records is an "up-and-coming" area that JCAHO will focus on, she says. "That transition [period], when some

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will be using both [kinds of records], is a vulnerable time. We're looking for processes designed to minimize those vulnerabilities."

JCAHO has in the works a task force on health information technology that will address those kinds of issues, Gilhooley adds.

Another important JCAHO focus has to do with eliminating the barriers to patient care sometimes posed by communication issues, she says.

"We've got a lot of standards that apply to language and culture," Gilhooley points out. "We want to ensure that patients' values and beliefs are respected, and [enable] patients' involvement in their own care."

While some of the emphasis is on provision of adequate interpreter and translation services, she notes, the communication challenges don't stop there.

"What we're finding when we look at language issues is that people who speak English are also having trouble understanding," says Gilhooley. "It's not just the health care provider imparting information; it's whether the other person understands."

Because so many medication errors occur at discharge, she adds, JCAHO surveyors are now asking questions designed to make sure the discharge conversation has actually been a two-way communication.

"They try to talk to a patient who has already been given discharge instructions if the person is still there," Gilhooley says, "but they can also ask to call and talk with one who has been recently discharged.

"We do have medication reconciliation as a new national patient safety goal," she notes. The idea is to know which medications the patient is coming into the hospital with and which ones they're supposed to be leaving with, Gilhooley adds. "Somebody should be looking at that and managing the whole patient." ■

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. ■