HOSPITAL CASE MANAGEMENT™

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

AHC Media LLC

IN THIS ISSUE

■ **CM training:** Home grown program reaps results . . cover

■ **Staff education:** Training helps CMs improve. 180

■ **Tracking delays:** Improving patient flow. 181

■ ***Critical Path Network:*** Eliminating potential delays . . . 183

■ **Guest Column:** Don't skimp on evaluation 189

■ ***Ambulatory Care Quarterly*** 191

■ **Inserted in this issue:**
— *HCM* 2006 Index
— Evaluation form for CE subscribers

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Case managers need extensive education, regular competency exams

Include new employees, longtime staff in the process

B.K. Kizziar calls it case management training by the "Poof!" method. "One day, you're a nurse on the floor. The next day, you're in the case management department and, within a week, Poof! You're a case manager. You have a caseload of your own, and the person who instructed you became a case manager exactly the same way," explains Kizziar, RNC, CCM, CLP, owner of B.K. & Associates, a Southlake, TX, case management consulting firm.

Few hospitals offer comprehensive orientation and educational programs for new case managers, she asserts. Most of the formal orientation is specific to policy and forms and what tasks they have to do every day.

Typically, after a short period of orientation that involves everything from hospital policies and procedures to regulatory requirements, new case managers have a short period of peer education before they're cut loose to work on their own, points out **Lorraine Larrance**, BSN, MHSA, CPHQ, CCM, manager with Pershing, Yoakley & Associates, a Charlotte, NC, health care consulting firm.

"Maybe new case managers spend a day or two with another case manager before going out on their own. This tends to perpetuate the idea that case management is task-oriented rather than process-oriented," Kizziar says.

Providing case managers only with internal education and knowledge perpetuates doing things the same way, even if it's not the most efficient or productive way, she adds.

"Developing a training and competency program for the case management department is extremely important, not only for new case managers but for case managers who are already within the organization," Larrance says.

Case managers who are new to the organization and the practice of case management need to learn the basics — what is case management,

what are the principles of practice, and what are the case managers' roles in your hospital.

"As a nurse, when I went into case management, I recognized that my clinical nursing skills were directed primarily to the patient's diagnosis and providing quality care, and with that skill set alone, I wasn't prepared for many of the daily case management activities. I didn't have the ability to pull from a set of core principles that direct the care management process, such as understanding and applying payer regulations. I didn't have the ability to look at the physician treatment plan and identify whether or not the patient was ready for discharge or to think in terms of getting the patient ready for the next step," Larrance says.

That's why case management directors should make sure that their case managers are educated about the case manager's role, case management processes, and all of the regulations that affect how they work, she adds.

"I am ultimately held responsible for what my case managers do or what they don't do. If I haven't taken time to educate them and bring them up to speed, it's my error," says **Lyn Clark**, RN, BSN, case management director at Lake Granbury Medical Center in Granbury, TX.

Because Granbury is a small town in a rural area, there is not a supply of experienced case managers, Clark says. Instead, she created the hospital's first training program for RNs who wanted to become case managers. **(For details, see related article on p. 180.)**

The education for new case managers should include topics such as medical necessity, avoidable delays, denials and appeals, and communication with payers and the interdisciplinary treatment team, Larrance says.

"Each of these different case management activities requires specific information related to that area, and they also build upon each other," she says.

Larrance suggests a series of six or seven core education classes from which you can build a competency tool.

Training should combine written work with one-to-one peer communication.

"This gives the individual an opportunity to practice making a determination of patient level of care or come up with a working discharge plan and to have immediate feedback from someone with a skill set that is much stronger than that of a new employee," she says.

It takes at least six months for a new RN case manager to be effective in his or her new role, Larrance says.

It's not enough to educate new case managers; case management training and competencies should be ongoing, in staff meetings, through written communications, and in formal educational sessions, Kizziar adds.

For instance, case management directors could send regular e-mails to the case management staff highlighting what is new or changes in regulations, then follow up in a staff meeting with details.

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"Case managers are right in the middle of the continuum of care. They're looking at processes from admission to discharge, and they should be aware of any procedural changes that can affect how they do their job," Larrance says.

The educational process must be ongoing in order for case managers to stay ahead of the curve with regulatory changes coming at them from all different perspectives," she adds.

Understand what drives processes

Larrance recommends that case management directors communicate with their staff weekly about any changes in reimbursement or regulatory requirements that may affect their job.

For instance, case managers may not need to know every detail of coding but they need to be aware of coding changes that potentially affect medical necessity documentation and/or the determination process because often they are the first people to notice that the correct documentation is not on the chart, Larrance says.

"All case managers should understand what drives the processes they use on a day-to-day basis. They should be aware of good stewardship of health care dollars and what impact what they do has on the rest of the interdisciplinary team. It's much easier for people to perform their functions when they understand the basis that is driving the process," she says.

For instance, when medical necessity determines the length of stay for a Medicare patient, case managers should be aware that the orders should clearly state the physician's intent and that documentation in the progress notes should support the diagnosis as well as the treatment plan.

"When a case manager is doing a review with a physician, it's helpful for them to know that the requirements will affect reimbursement and that it's not just something the boss made up," Larrance says.

Case managers in the hospital setting don't always have an opportunity to see each other regularly and exchange ideas on how to manage the care of patients, Kizziar adds.

"When I have consulted with hospitals, I have observed that most of the communication is done by e-mail, but regularly scheduled departmental meetings are essential to discuss regulatory and other changes and how they affect the way the case managers will do their work," she says.

Regularly scheduled department meetings are very important because they give case managers an opportunity to ask questions about changes in regulation, to discuss what they have found effective, and to receive input from other people in the department, Kizziar says.

"I believe that in order to maintain a sound case management department, the staff should attend periodic educational sessions that focus on the core level of case management principles, the core values of what case managers do," Larrance suggests.

If there are new trends or just a particular area within an organization that needs focus, case management directors should bring their staff together and educate them, she adds.

Bring in outside resources to educate your case managers, Kizziar suggests. For instance, invite someone from one of your managed care payers to talk to the case managers about how their company's reimbursement system works, or ask someone from the Centers for Medicare & Medicaid Services to talk about reimbursement.

"Most important is for hospitals to provide support and financial aid for outside education so there isn't a vacuum within the hospital where little information gets in or out. Employees can greatly benefit from outside resources," she says.

Kizziar laments the fact that few employers support continuing education for case managers, eliminating the benefits of attending a conference or class and meeting their peers.

"Professional organizations can provide case managers with excellent overviews of what is going on in the case management world. If the director and/or staff members are active in their local organizations, this can help the case management staff stay current not only with regulations but with what is going on in the community," Larrance says.

Competency programs may differ from hospital to hospital, depending on the case managers' role in the organization.

Look at the role of the case manager within your hospital and set up a monitoring system to evaluate the process, Larrance suggests. Look for gaps to identify areas where you need to educate your staff.

"This not only helps educate the experienced case managers but is extremely helpful when you bring an RN into a case management role," she adds.

Start by creating a job description and base your competency on that, Kizziar suggests.

A case management job description has to be specific to the hospital's objectives and must have

measurements attached that are objective, not subjective, she says.

Create a career ladder specific to case management so that it ties in with continuing education, achieving certification, and other education, she says.

For instance, when a new case manager comes into the department, he or she must meet a list of objectives in order to become a Case Manager 1.

When the case manager meets the requirements for the Certified Case Manager exam or other internal requirements, he or she becomes a senior case manager, with a corresponding increase in salary.

Review each case manager's performance at least annually based on the objective measures in the job description Kizziar recommends.

For instance, audit discharge outcomes, resource management, averted costs, and avoidable days.

"The effectiveness of the discharge plan can be measured by following up with patients 72 hours after discharge with a short list of questions.

"This also gives us an opportunity to re-empower the patient and family to be their own advocate and to direct their own care," she says.

Use clerical staff to make the follow-up calls.

Anyone can do the follow-up call because it is a list of objective questions and doesn't involve actually managing the care of the patient, she says.

"If issues are discovered that may endanger the patient or need immediate attention, whoever is making the call can advise a case manager, who can direct the patient or family to the most appropriate resources," she adds.

Preparation for professional competency examinations is another area in which hospitals can help their case managers learn to do their jobs better, Larrance says.

One hospital she worked with held educational sessions for a group of case managers who were preparing for the CCM examination.

The case management director collected information about some of the more obscure areas of the test and provided education for the entire staff.

"It was very much appreciated by those who were preparing for the test and also acted as a stimulant for those who were not taking the examination because studying for the exam didn't seem to be so overwhelming," she says.

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Education helps CMs learn to do their jobs better

Training modules help nurses adapt to new role

When **Lyn Clark**, RN, BSN, became case management director at Lake Granbury Medical Center in Granbury, TX, she found herself with a staff working with no direction and who had very little knowledge about the role of case management in the hospital setting.

That was 18 months ago. After she developed and implemented an intensive training program for case managers, Clark has received accolades about her case managers' performance from her hospital's corporate office and, best of all, she can take a vacation without anyone calling her with questions.

In the first year, after the program was redesigned, the case management department was able to demonstrate that it had tripled reimbursement by improving documentation. **(For details, see *Hospital Case Management*, August 2006, p. 117.)**

"The first thing I did when I came in was to talk with the case managers to assess their skills and find out what they were doing on a daily basis, then make suggestions as to how to perform their role more effectively," she says.

The hospital has two case management FTEs, split into three positions. Two of them work four days a week. The other works two days. Between them, they provide coverage seven days a week. A full-time case manager covers the emergency department 40 hours a week.

It took Clark about three months to get her case managers on track to performing genuine case management duties instead of running errands for physicians or helping at the bedside.

She repeated the same message over and over — that the case managers were going to focus on case management duties and not other tasks to which they had previously been assigned.

"It took some of the hospital staff as long as nine months to understand that some of the things the case managers were doing were not appropriate. I had to take a lot of heat and re-educate the nurses, the physicians, and the rest of the hospital staff about the role of case management," Clark says.

"In the beginning, I talked to the case managers about their role as nurses and how critical

nursing skills play into case management," she says.

For instance, Clark suggested that the case managers evaluate whether the physicians were ordering what they expected to see when they worked on the floor. She found that case managers needed to change the way they worked with patients.

For instance, if there is a patient on a ventilator who is not likely to be discharged soon, the case managers need to concentrate on a patient who may be discharged the next day.

"With a ventilator patient, there's no point in picking the medical record apart because they aren't moving any time soon," Clark explains.

She covered basic information, such as which insurance company wants clinicals every other day and where the information should be sent.

"I went over Medicaid, assessing what the case managers know about Medicaid, such as the income level families must have to qualify," Clark says.

Clark keeps three-ring binders filled with pertinent information on case management issues that she can turn into a presentation or an educational tool.

Using that information, she pulled together training modules for her case managers, along with a series of 20-25 questions on each topic.

Topics include: Medicare regulations and documentation, Medicaid, one-day stays, EMTALA, acronyms used by case managers, DRGs and DRG payments, observation vs. admission status, and case management duties.

Case managers cannot finish orientation until the packets are complete.

"Some of the answers are not easy. They have to come to me or to their peers and have that dialogue. Working with their peers helps build relationships, and now they have camaraderie with the other case managers," she says.

The original case managers took longer to complete the orientation packets. Those who were hired later completed the process more quickly because they had support from their peers.

When the case managers turn in the packet, Clark sits down with them and goes over the contents.

"I want to make sure they know what they think they know. If they don't understand it the right way, I have the opportunity to fill in the gaps," she says.

Clark makes it clear to her new case managers that they have 90 days to meet her expectations.

"I tell them I am here for them and I want them to be successful, but it's their responsibility to call on me to educate them about what they don't know," she says.

Clark regularly gives the case managers handouts showing changes in policies and procedures and changes in payer regulations.

"Our business is information. The hospital pays us for what we know and how we can plug patients into what they need," she says.

Clark reviews case managers for competency on the anniversary of their hiring. What kind of raise the case manager gets depends on an annual evaluation.

"I don't wait until the year mark if they have an issue. If I see they're struggling with something, I sit down and talk with them. It gives them back their comfort level," she says.

Clark extends her educational efforts to the hospital's attending physicians, providing them with updates on payer requirements and Medicare and Medicaid regulations and how it affects the hospital.

"As I educate the physicians, the case manager's job is easier because the physicians aren't hearing it for the first time when the case managers ask them for more documentation or something else," she says.

Clark makes a presentation at the hospital's orientation session for new physicians, educating them about the role of case management and how they can help the physician and their patients.

(For more information, contact Lyn Clark, RN, BSN at e-mail: zlaclark@hotmail.com.) ■

Tracking delays cuts LOS, improves patient flow

More discharges take place in the morning

A process that tracks delays in service at Calvert Memorial Hospital in Prince Frederick, MD, has improved patient flow by ensuring that tests and procedures occur in a timely manner.

"We've seen some drop-off in length of stay, in terms of hours since we began the process. Our length of stay has always been relatively low, running between 3.4 and 3.5 days. What I have seen since we started this initiative is that our systems are running better. We are identifying

breaks in the system and working on ways to improve them," says **Jennifer Stinson**, RN, BSN, CCM, director of case management.

Since the initiative began in mid-2005, the hospital has increased the percentage of patients discharged in the mornings from 15% to 35%.

"To me, the fact that the initiative shows an increase in discharges earlier in the day means that our systems are working better," Stinson says.

Case managers have the primary responsibility for collecting and reporting delays of service.

"The case management team reviews every patient every day. This puts them in a position to see that everything that needs to be done is done and allows them to identify system failures in the hospital," Stinson says.

The hospital's case managers fill out delay-in-service forms, which they turn in to the risk management office. The risk management office forwards the delay in service forms to the responsible department, which has 48 hours to respond. The risk manager enters the reports and the responses of the department heads into the computer.

"We send them to nursing, laboratory, case management, the medical staff. Any time there has been a break in a patient receiving service in a timely manner, we note it and forward it on for a response," Stinson says.

The case managers have copies of the delay in service forms with them at all times. In addition, there is a supply on all nursing units and any staff member can fill it out and send it to the case management department.

"It's a user-friendly form that takes only a minute. The staff fill out what department may be responsible for the delay and writes a note and that's it," Stinson says.

Risk management tracks the incidents and analyzes them to look for trends, printing out trend reports every month.

"The initiative allows department managers to keep trending down and keep drilling down to get to the problem. It won't go away on its own but will keep showing up month after month," she says.

Each department head gets a copy of the individual forms and data showing trends.

"Some departments have never had a trend. We're a small hospital. A trend could be just five incidents," she says.

Some departments have had only one incident of a delay occur and it's never happened again because the department head took care of it with education. For instance, if there is a delay in a case management task that continues over a month, Stinson looks at the incident as an opportunity for education for the entire case management staff.

"The delay in service initiative is not used to telling departments that they have to do things a different way. It's to show us what is broken, and sometimes we don't know exactly what is broken until we look at the trends," she says.

Staffing increases

Department heads have been able to use the delay in service trends as a way to justify an increase in staff.

"A lot of the time, we knew there was a problem but were having a hard time getting the data to demonstrate that there is a problem and exactly what the problem is," she says.

When trends are identified, a multidisciplinary team examines the trends and looks for ways to reverse them.

The department heads have 48 hours to respond to the delay in service reports.

For instance, when the initiative began, the case managers became aware that blood draws that were ordered for the morning were often getting done later in the day and the results were not back in time for the patient to be discharged that day.

At Calvert Memorial Hospital, the nursing staff works two shifts — 7 a.m. to 7 p.m. and 7 p.m. to 7 a.m.

The blood draws are the responsibility of the nurses on the morning shift. If they couldn't complete the blood draws, they left the task for the day shift nurses, who often were involved in other matters early in the morning. When the physicians came on the floor in the mornings, looking for lab results, they found that the results were not available because the blood draws hadn't been done.

Now when the morning shift nurses cannot complete a blood draw, they put the orders in a telephone caddy, which is picked up by the lab transporter, who also is a phlebotomist.

The phlebotomist does the lab draws that haven't been done, ensuring that the lab can get the results back in a timely manner.

"It works great. We no longer have delays for that reason. The labs are drawn, the doctor is notified early in the morning, and discharge is not being delayed because we are waiting on lab results," Stinson says.

(Continued on page 187)

CRITICAL PATH NETWORK™

Demonstration project claims $1 billion in potential savings

Premier, CMS collaborative projects 3,000 fewer deaths

Data from Premier Inc.'s pay-for-performance demonstration project with the Centers for Medicare & Medicaid Services (CMS) indicate that improving the care of pneumonia and heart bypass patients alone can save as much as $1 billion a year, as well as thousands of lives. Projected outcomes include 3,000 fewer deaths, 6,000 fewer complications, 6,000 fewer readmissions, and 500,000 fewer days in the hospital.

Through the demonstration project, Premier collects a set of 33 quality indicators from more than 250 hospitals across the country. Because these indicators are not collected from all hospitals, Premier researchers extrapolated national implications using statistical methods. If patients receiving a smaller percentage of widely accepted care measures had instead received most of the measures — 76% or more — hospitals costs would have been approximately $1 billion lower in 2004, according to Premier's analysis.

"The first year the project collected data was 2003," says **Denise Remus**, PhD, RN, Premier's vice president of clinical informatics. Formerly, she was senior research scientist at the Association for Healthcare Research & Quality (AHRQ), where she was responsible for the development of AHRQ's quality indicators. "In spring of last year, we closed the first-year data set, and results were released in November 2005. When I joined Premier, I took the first year of the demonstration project and began to do an analysis of the relationship between cost and quality," she says.

As she began her analysis, Remus recalls, she did not see a relationship between individual process measures and outcomes. "This actually made sense," she says. "Several of the measures have to do with discharge. For example, with heart failure, one of the measures is discharge planning; in AMI, one is beta-blocker prescribed at discharge. So, it made sense to not see a relationship between individual process measures and outcomes during stay."

While her "gut" told her there was a relationship, Remus couldn't see it. "I stepped back and said, 'Let me ignore where the patient was taken care of and merge all the patients together and look at the quality on the patient level.'"

In essence, Remus says, she relied on a "pathways of care" approach. "What that says is, we know we have patients who are eligible for a certain number of measures. In my mind, high quality is when the patient gets everything they are supposed to get. So, instead of just looking at whether the patient was getting aspirin, we looked at a proxy — patient process measures — and the rate of how many interventions patients were eligible for and how many they actually received."

In other words, a patient who goes through the health system and receives all the recommended experiences around the measure is receiving highly reliable care. Accordingly, the patients were placed in four groups from low to high, in segments of 25% reliable care — the highest being 76% or more. "Then, we looked within each of the clinical conditions [pneumonia and heart bypass]," says Remus.

Using the data

In order to come up with the estimated savings, she says, "We took the analysis we had done, and then estimated what the impact might be nationally,

based on the Healthcare Cost & Utilization Project database of AHRQ — and identified how many patients were discharged in pneumonia and heart bypass. Then, we looked at the total number of patients discharged in those groups and estimated how many would be in the low, medium, and high categories based on how the patients in our projects were distributed."

Remus thinks her numbers are actually conservative, "because in our year of data, our hospitals tended to have higher quality than other hospitals in the country."

These data carry an important message for hospital quality managers, says Remus. "As Medicare moves into value-based purchasing, or linking payment to quality, hospitals will have to manage their costs better," she says. "That's the group we want to address."

She continues: "We believe we've established clear evidence that higher quality can improve outcomes and save costs," Remus asserts. "We've also found that it doesn't cost more to get high quality, which, of course, reduces LOS and complications — all of which increase the costs of care for patients."

Readiness program

To help hospitals move in the right direction, Premier has launched a pay-for-performance readiness program, which is provided free of charge on the company's web site (www.premierinc.com/). The program includes a pay-for-performance calculator.

"Anyone who has a Medicare provider number can enter it," says Remus. "Then, in the next screen it asks them to enter a numerator and denominator for the 18 process measures in AMI, heart failure and pneumonia."

Once those numbers are entered, the site will come back with a report that links cost and quality. "Using their information, we calculate an 'appropriate care score' at the hospital level," Remus explains. In other words, the report will show how many patients treated at your hospital for AMI and pneumonia received appropriate care. "Then, we model what their potential cost savings would be," she adds.

"This just helps support awareness that there is a changing reimbursement environment out there," she continues. "Payments can potentially be reduced or increased based on quality. In that environment, hospitals may be at risk if they do not provide high-quality care, so they need to take a look at the reliability of their care system." ■

Project participants reaping the benefits

Improvements seen in CHF, AMI measures

Facilities that are participating in the Premier/CMS demonstration project already are seeing the benefits in improved quality — not to mention the attendant incentives. For example, Cleveland Regional Medical Center in Shelby, NC, has seen dramatic improvement in congestive heart failure (CHF), acute myocardial infarction (AMI), and hip and knee core measures.

"We started with CHF, because it had the biggest opportunity for improvement," recalls **Elizabeth Popwell**, CHE, vice president of systems management, who says the facility's baseline year was 2003.

"Our readmission rates were much higher than benchmark — 12.09%," she says. "We were really concerned, what with the advent of pay for performance."

One of the things that appealed to her about the demonstration project was its weekly monitoring tools. "We felt that would help us in our journey to improve," she says. "What we had done historically for QI initiatives was retroactive chart reviews. In CHF, for instance, that would probably mean looking back on a given quarter four to six months later. I knew of no way to meet our vision if things continued that way."

With the demonstration project, she says, "We'd be able to collect data concurrently, monitor results in real time, and make the necessary adjustments." Thus, her hospital's entire PI model was changed. "Formerly, PI teams would languish on for 18 months, which is very ineffective," says Popwell. "We already know the evidence and what best practices are."

So, as participation in the project began, Cleveland Regional decided to employ rapid cycle changes. "Then, we hired a staff person to do nothing but round on patients — review charts and see if they were getting what they needed," Popwell explains.

When the individual, who is an RN, started, she looked at issues such as whether a patient got his or her LVS (left ventricular systolic) function tests, or if his or her ejection fraction was on the charts. "If it was not, she would talk to the physician or nurse and ask why," says Popwell. "We call it an 'expediter' role; she made sure nothing

slipped through the cracks."

Popwell admits that initially, some doctors would have given her a different, less flattering name, but that was before they saw the results. "We not only met the benchmarks, but we improved outcomes," she says. "In 2005, our readmission rate was down to 7.6%."

As for discharge instructions, in the baseline year 12% of patients went home with appropriate instructions. "After our first year, 96% were going home with them," notes Popwell.

The return on investment for the new position is "phenomenal," says Popwell, who is getting ready to hire a new "expediter."

Once she saw those results, Popwell and her team moved straight onto AMI. "We had gained so much buy-in from the docs, once we showed that our 'aggravating' led to significant improvements," she shares.

PI approaches

The same held true for AMI. Mortality in the baseline year was 8.57%; in one year it was reduced to 6.47%. "We've had similar results for hip and knee," says Popwell. "Our 2003 baseline for knee surgery infection rates was 2.6% — the worst decile. In one year, we went to 0.9% — the best decile. Hip surgery infection rates were also reduced — from 2.8% in 2003 to 1.81% in 2004.

"We've maintained the improvements, too," says Popwell. "A lot of our core measures are in the top 10%; in fact, if we drop below 95%, I get nervous."

At Aurora Sinai Medical Center in Milwaukee, the quality improvement team has seen improvements in community-acquired pneumonia through its participation in the program. *(Editor's note: As we went to press, data still were being finalized.)*

"As we received the data from Premier and CMS, we used it to look at what processes we could improve on," recalls **Ann Staroszczyk**, RN, MS, director of quality. "We started with CAP."

"Some of the processes we focused on were obtaining blood culture prior to antibiotics, antibiotic selection for ICU patients, and timing to first antibiotics and influenza pneumococcal vaccines," adds **Michelle Sarnoski**, quality coordinator for the pneumonia initiative.

One of the major activities embarked on was a monthly meeting with the ED, she says. "We'd review the pneumonia charts from the previous month and look at processes and how we could improve," Sarnoski relates.

One of the PI approaches selected was to have the ED director give positive feedback to the staff who performed well on the pneumonia initiative. "He also pointed out to them when they were not meeting the standards, but he gave them a lot of positive reinforcement when they met them," says Sarnoski. This reinforcement was given in writing, and the department created a "Wall of Fame" where their names were posted.

If patients come in with signs and symptoms of pneumonia and are treated within the appropriate time period (i.e., blood cultures, pulse oximetry) there are forms that can be filled out that in essence say to the staff member, "Great job; we're proud of you," says Sarnoski. "When somebody sees someone else on the 'Wall of Fame,' it becomes and incentive for them to get up there as well."

The bottom line, she says, is that "It's the daily attention to detail that makes the program a success." ■

HHS issues Privacy Rule decision tool

The Department of Health and Human Services' Office of Civil Rights has issued a decision tool for disclosures for emergency preparedness under HIPAA.

The document says emergency preparedness and recovery planners are interested in availability of information they need to serve people in the event of an emergency. For example, planners seek to meet the special needs of the elderly or people with disabilities in the event of an evacuation.

HIPAA's Privacy Rule permits covered entities to disclose protected health information for a variety of purposes. The Office of Civil Rights says the tool presents avenues of information flow that could apply to emergency preparedness activities.

Emergency preparedness

The rules regarding the use and disclosure of protected health information could apply to all individuals, with no special rules applying to particular populations, such as persons with disabilities.

The Office of Civil Rights says the tool does not address other federal, state, or local confidentiality rules that may apply in specific circumstances. For example, disclosures permitted by the Privacy Rule for public health would generally be prohibited

under federal substance abuse confidentiality law. Because the tool focuses on issues relevant to emergency preparedness, the tool does not present all the uses and disclosures permitted by the Privacy Rule, nor does it discuss all the rule's requirements.

To guide planners in determining how the Privacy Rule applies to disclosures for emergency preparedness, the tool focuses on the source of the information being disclosed, to whom the information is being disclosed, and the purpose of the information being disclosed.

More information is available on-line at www.hhs.gov/ocr/hipaa/decisiontool. ■

Joint Commission revises look-alike/sound-alike list

For the first time in several years, the Joint Commission on Accreditation of Health Care Organizations has revised the look-alike/sound-alike drug list.

In addition to identifying pairs or groups of medications that can easily be confused, the list identifies potential complications and strategies to avoid confusion. Medication pairs added to the list for home care programs are: hydroxyzine and hydralazine, metformin and metronidazole, and OxyContin and oxycodone. Medication pairs deleted from the list are: cisplatin and caroplatin, fentanyl and sufentanil, lantus and lente, and taxol and taxotere.

Home care managers can view the list at www.jointcommission.org. Go to "patient safety" on top navigation bar and select "National Patient Safety Goals." Look under " 2007 Resources" and select "Look-alike/sound-alike drug list." ■

CDC: Fire away with flu shots, more vaccine coming

The Centers for Disease Control and Prevention is working with influenza vaccine manufacturers to try to smooth out supply problems and ensure all providers get their slated doses, said **Jeanne Santoli**, MD, MPH, deputy director of the Immunization Services Division at the CDC National Center for Immunization and Respiratory Diseases.

"There have been 40 million doses that were distributed to providers as of the end of the second week of October, and we are still on track to achieve 75 million doses to be distributed by the end of October," she said at a recent CDC press conference. "This is 15 million more doses that are compared to last October in terms of flu vaccine distribution."

The CDC projects some 115 million doses will be distributed this year, but there are some inevitable shipment delays because all the vaccine is not produced before the annual flu season begins.

"So this means that influenza vaccine distribution takes place in a phased fashion over a number of months," Santoli said. "It begins in late summer for some manufacturers and completes near the end of November or early in December. In addition, because the production and approval of doses is ongoing, it isn't easy to predict exactly when a particular order will be delivered very far in advance. Unfortunately, this situation leaves providers with the uncertainty about knowing when they can expect to receive their full order and the challenge that makes for their planning of vaccination activities."

Wide distribution

Though noting that "it is not possible for us to take away that uncertainty," Santoli said the CDC is trying to get some vaccine to a wide number of providers in order to allow immunization of high-risk patients and their household contacts.

"CDC is encouraging providers to take this phased nature of vaccine production and distribution into account as much as possible when they're planning how they'll vaccinate their patients," she said. "Almost all providers have some vaccine to allow them to begin vaccinating their patients, and we recommend beginning vaccination now, rather than waiting until more vaccine arrives."

More vaccine will be arriving throughout the season and providers should continue immunizing well into January 2007. "Vaccinating beyond November is important and beneficial because the peak of the season typically occurs in February or later and we know that many high-risk persons and their household contacts are recommended for vaccination but are not vaccinated by the end of November," Santoli said. ■

(Continued from page 182)

Within 30 days of identifying the trend in delayed blood draws, the team had come up with the idea of having the phlebotomist perform whatever draws had not been done.

"We saw the trends and broke it down to where the problem was, then fixed it," she says.

Another initiative involved making sure that the Foley catheters are removed as quickly as possible following orthopedic surgery.

"We were finding out that on the day the patients were ready for discharge, the catheters were still in. Instead of discharging them on the morning of Day 2 or 3, we had to pull the Foley and keep the patients until they could void. Instead of a 10 a.m. discharge, the patients might stay until 3 p.m. or 4 p.m.," Stinson says.

The team revised the order sets for orthopedic patients, adding the order to remove the Foley catheter at the same time the nurses disconnect the PCA pump for pain control and discontinue IV fluids. The risk management department tracks the trends for the system.

Changing the order sets to include removing the Foley catheters took around two months because the physician staff had to be involved.

"In the meantime, we made everyone aware of it and alerted them to get the Foleys out in a timely manner," Stinson says.

The case managers began looking at the order sets first thing in the morning to make sure everything was being completed.

The hospital has 13 case managers who are assigned by physician. The average caseload is 12 to 15 patients at a time.

The case managers are responsible for utilization review, discharge planning, clinical documentation improvement, teaching, monitoring core measures, and other quality initiatives. The staff works six days a week and is on call on Sunday.

(For more information, contact: Jennifer Stinson, RN, BSN, CCM, jstinson@cmhlink.org.) ■

Team educates staff, ensures compliance

Hospital receives award for significant improvement

Having a dedicated team ensure compliance with the core measures has resulted in significant improvement in patient care quality at Cheyenne (WY) Regional Medical Center.

The hospital was one of only five Wyoming hospitals to receive a 2006 Quality Achievement Award, the highest award given by Mountain Pacific Quality Health to hospitals that show a high level of compliance or significant improvement on 14 of the 22 quality measures established by the Centers for Medicare & Medicaid Services (CMS) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

To qualify for the award, a hospital must demonstrate a 20% decrease in failure rate on 14 of the 22 indicators or maintain a 90% or higher performance rate for at least six consecutive months on the indicator, or achieve a combination of the two options. Cheyenne Regional Medical Center met the criteria for the combination of the options.

At Cheyenne Regional Medical Center, dedicated staff follow the hospital's compliance with the core measures quality indicators.

Christine Kercher, RN, core measures case manager, follows the patients with heart failure and pneumonia. **Marlene Griffith**, RD, the medical center's cardiovascular clinical data analyst, works to ensure compliance on the myocardial infarction (MI) core measures.

Until the dedicated team was established in 2005, all case managers at the hospital were responsible for the core measures.

Kercher and Griffith operate independently and have different ways of gathering data and monitoring compliance, but their common goal is to make sure that all patients eligible for the core measures receive the recommended treatment unless it's contraindicated.

The core measures team works to create awareness of the core measures and their importance throughout the hospital and works with clinicians to make sure they are compliant with the quality initiative.

Kercher meets every month with the emergency department nurse managers and the head physicians and provides a list of all of the patients who fall out of the core measures.

"We've been having these meetings for about nine months, and it's been very beneficial. It's not often that we have a pneumonia patient who is admitted from the emergency department without having received the initial dose of antibiotics," she says.

The meetings give the emergency department physician the opportunity to say that the focus was not on pneumonia but was on another diagnosis, Kercher says.

When antibiotics were ordered but not given in the emergency department, the nurse manager talks with the staff nurse and reinforces the importance of giving the antibiotic in a timely manner.

When the lapse occurs on the nursing unit, Kercher contacts the nurse manager and talks with the staff nurse to reinforce that the antibiotic needs to be given.

"We try to keep everybody abreast of what is going on," she says.

Reasons for improvement

Griffith cites three factors in the hospital's improvement on the AMI measures: creating an awareness of the core measures among the entire treatment team, starting with emergency personnel; developing an action plan to move patients from the emergency department to the catheterization lab as quickly as possible, and timely reporting and reinforcement of progress.

Griffith started providing data to the heart center's multidisciplinary team in 1999 when the cardiologists initiated a study to track the outcomes of what ultimately became the core measures. She continues to bring core measures data to the multidisciplinary team.

"Early on, our baseline data demonstrated opportunities to improve outcomes for AMI patients. We've communicated core measures information for several years," she says.

Griffith collects data concurrently and makes monthly reports to the multidisciplinary team and the cardiology staff and quarterly reports for the telemetry staff and the emergency department nurse managers. She posts graphs demonstrating the progress on compliance with the core measures in the emergency department, the catheterization lab, and on the telemetry unit.

"Everybody knows where we are at all times," Griffith says.

"Chart reviews are performed whenever a case is an outlier for door-to-open-artery in more than 90 minutes. The review assists the team in pinpointing where we can improve," she says.

Recently, the hospital has added representatives from the local emergency medical service and the community ambulance service to the heart attack team.

The representatives attend the meetings and take an active part, particularly with issues that concern the "pre-door" cases, patients with heart attacks who are transported to the hospital.

This year, the community representatives assisted in writing an AMI algorithm and getting it approved by the agency that regulates emergency medical personnel.

Now emergency personnel can give heart attack patients certain drugs, such as aspirin and beta-blockers in the field.

"It's been very helpful when they can give aspirin and beta-blockers when appropriate under the guidance of their algorithm and they document it for us," Griffith says.

Kercher screens all of the new admissions every day, looking for indications that the patients have a diagnosis of heart failure or pneumonia.

When a patient has a condition that is included in the core measures, she puts a fluorescent green sheet into the patient record to alert the treatment team. The sheet has a check-off list of all the indicators for that particular condition and a place where Kercher can write reminders for documentation.

She attends the daily meeting of all the case managers, representatives from quality improvement, infection control, wound care, diabetes, and other hospital departments.

"We go over who they have identified as potentially having heart failure or pneumonia and compare them to the patients I have identified," Kercher says.

When patients are admitted to a surgical or neurological floor with a secondary diagnosis of pneumonia or heart failure, the case managers alert Kercher. They also let her know when they are treating a patient who has a history of heart failure or pneumonia, even if that is not a reason for hospitalization.

"We communicate by e-mail and in person. I'm in continuous contact with the case managers so they can alert me as to a patient to follow up on. The system works well. We all communicate with each other to make sure that we identify every patient who falls under the core measures," says Kercher.

She visits every patient with a diagnosis of heart failure or pneumonia and makes sure they are aware of what they need to do after discharge to manage their condition.

As Kercher talks with patients, she reminds them of the importance of filling their prescriptions after discharge and notifies the case manager or social worker if the patient might need financial assistance

with his or her medication.

"Some of the patients have been living with congestive heart failure a long time. I urge them to contact their doctors if they have a question about their condition so they can avoid rehospitalization," she says.

When another staff member has not completed the smoking cessation initiative, Kercher does it.

Kercher has worked with the hospital's physicians to change the discharge instructions for heart failure patients to include ACE inhibitors and beta-blockers and a space to document contraindications if the medications are not prescribed. "I've worked with the physicians to make sure the medications are prescribed and, if they are not, that there is documentation to support their decision," she says.

Griffith collects data concurrently, reviewing the ICU and telemetry census reports every day.

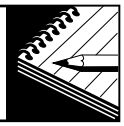
"By reviewing the charts, I pick up on patients who don't come through the emergency department, such as elderly people who present with nontraditional symptoms but we find out after admission that they had a heart attack," she says.

The hospital's case managers alert Griffith when a patient with a diagnosis of AMI is admitted to a medical floor.

"Everybody is tuned into the core measures, and they let me know if they have a patient whose care falls under the core measures," she says.

She has worked with the multidisciplinary team to create a discharge instruction form, slated for implementation in late 2006, that includes the AMI core measures and discharge indicators. ■

GUEST COLUMN



Don't skimp on evaluation

Make sure changes are effective

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

It is pointless being really busy improving your case management services if you don't also make sure that the changes being made are as effective as they could be. You also need to be sure that you are making the right changes. This is where evaluation becomes important. Evaluation is all about checking that you are doing things right and doing the

CE *questions*

21. How long does it take for a new case manager to become effective in her role, according to Lorraine Lorrance?
A. 90 days
B. 60 days
C. Six months
D. One year

22. Which of the following topics is included in the case management training modules at Granbury Medical Center?
A. Medicare regulations and documentation
B. Medicaid one-day stays
C. EMTALA
D. All of the above

23. An initiative to cut delays in service at Calvert Memorial Hospital has increased the percentage of patients discharged in the morning from 15% to what percentage?
A. 35%
B. 25%
C. 30%
D. 20%

24. At Cheyenne Regional Medical Center, chart reviews are performed on all outlier AMI cases. What amount of time must elapse between the time the patient is admitted and the time an artery is open for the patient to be considered an outlier?
A. 60 minutes
B. 30 minutes
C. 45 minutes
D. 90 minutes

Answer key: 21. C; 22. D; 23. A; 24. 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. **The semester ends with this issue.** You must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

right things. Without evaluation, the value of new case management initiatives cannot be adequately judged. Evaluation will help to determine whether your goals have been achieved as well as look at what worked best. Evaluations can be small and simple, as well as complex. They need not be labor-intensive, particularly if they use routinely collected information.

Evaluation of your improvement activities, however small, also helps spotlight the achievements of the case management department. Through dissemination of findings, accomplishments can be recognized and shared with others. In addition, the findings from many small evaluations in various departments provide a wealth of information about service improvement, both what works within case management services areas and across the entire organization.

Often, the most challenging part of evaluation is determining what to measure. Your choice of measures is influenced by what you are trying to achieve. There are three different areas of interest for an evaluation. They are:

- **Project monitoring:** looking at the routine functioning of your improvement work. Is it doing what you wanted it to do?
- **Process evaluation:** looking at the way in which your improvement work is implemented and runs. What can you learn from the process?
- **Impact evaluation:** looking at whether your improvement work is delivering the objectives set. Are you getting the outcomes you planned for?

These areas are not mutually exclusive. They can each be the sole focus of an evaluation or can be combined for the evaluation. It is important to be clear about the focus of the evaluation from the outset.

At the planning stage, you also need to be clear about what information is required for the evaluation. There may be routinely collected information that can be used, or additional information may be required. If nonroutine data are to be collected, you'll need to determine whether the information can be gathered with sufficient reliability and whether the people assigned data collection responsibilities have adequate time to do so given their other job demands.

To ensure your data collection efforts provide worthwhile information, a number of issues must be address prior to the start of the evaluation. Start by developing a plan for evaluating the activity. For instance, you may have recently expanded case manager coverage to the weekends. Prior to this time, case managers were only on-call during the weekend. Now a case manager is in-house during the day on Saturday and Sunday. You'd like to evaluate this change in service. To help get you started on the evaluation, develop an evaluation plan that considers:

- the questions to be answered;
- the data to be collected, together with methods of collection;
- how long the evaluation will take;
- who will do what in the evaluation;
- how the results of the evaluation will be disseminated.

Be clear about the data needed. Where possible, data that are routinely available should be used. Specific data may be required for the evaluation which is not already collected routinely by case managers. It is critical that a practical approach to collecting the data is developed and that those collecting the data are able to collect it in a way that does not impact on their day-to-day work. Your evaluation can fail if this has not been

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. ■

COMING IN FUTURE MONTHS

- ■ Helping patients deal with end-of-life issues
- ■ How new CMS regulations affect your job
- ■ Why documentation enhancement is more important than ever
- ■ Using technology to improve patient throughput

thoroughly considered.

There are several approaches that can be chosen to evaluate your improvement activity.

Consider the following four questions in determining the type of evaluation you need:

- Do I want to assess the impact or outcome of the new or changed case management process against stated goals, or do I want to assess the impact by evaluating intended and unintended effects?
- Do I want to assess whether outcomes are directly due to the new or changed case management process, or do I want to explore what is affecting outcomes?
- Do I want to measure the success of the new or changed case management process by judging it against the goals of a single stakeholder (e.g., case managers) or against the goals of a wide range of stakeholders?
- Do I want to determine whether the new or changed case management process actually works as expected, or do I want to determine where improvements are needed?

In preparing the design of the evaluation, there are several key areas to consider, each of which will shape the design of the evaluation and methods used. You may wish to design a summative evaluation. This is a one-time evaluation used to make a judgment about the success of an improvement project to show whether the project worked and whether it met its goals. Key questions might be:

- Did the improvement work achieve its objective?
- What improvements were created?
- What benefits did the project deliver compared to what it cost?

A formative evaluation is ongoing. This type of evaluation looks at the new or changed case management process as it evolves and suggests ways in which it can be improved. The emphasis in a formative evaluation is to determine why or how a project produces specific results. Key questions might be:

- What have we learned?
- What were the drivers for change?
- What were the obstacles for change?
- How did the initiative change over time?

Once your evaluation plan is formulated, explore the plan with the case managers as well as other stakeholders. Get everyone's input into the key aspects of the evaluation and who is responsible for what.

If you set out knowing what you want to achieve with new or changed case management processes but don't plan effectively, it will take a very long time to achieve your goals. You may never actually realize your improvement objectives. Planning for the evaluation of your improvement project is just as important as the planning that goes into making changes. Evaluation is an essential and regular part of all improvement activities. It will help you determine whether your aims have been achieved as well as point out what additional improvements are needed. ■

AMBULATORY CARE QUARTERLY

Elderly AMI patients don't always get beta-blockers

Those who need them most are less likely to get them

When elderly patients with acute myocardial infarction (AMI) come to emergency departments (EDs), they are less likely to be given beta-blockers than younger patients, says a new study.

Of 270 patients with ST-elevation myocardial infarction (STEMI) who did not receive beta-blockers, 59% were older than age 60. "Elderly patients with AMI tend to have worse outcomes than younger patients and have the greatest potential for benefit with beta-blockers,"[1] says **David D. Vega**, MD, assistant program director of the emergency medicine residency program at York (PA) Hospital. "These may be the very patients who receive them the least."

Collaborate with physicians to develop educational programs regarding the benefits of beta-blockers for AMI patients, he recommends. "This may help to promote an understanding of the great extent of benefit with these medications, which is often underestimated by practitioners."

Many ED nurses may have misconceptions about the true contraindications to beta-blockers, says Vega. "One of the big misunderstandings regarding the use of beta-blockers is that a history of [congestive heart failure] alone does not preclude their use. They are contraindicated in the

setting of an acute exacerbation of CHF." The same criteria apply with chronic obstructive pulmonary disease (COPD) and asthma: Beta-blockers are contraindicated only in patients with acute exacerbations of COPD and asthma, not all patients with a history of these conditions, he adds.

The bradycardia contraindication applies for heart rates below 60 bpm, he adds. "Despite the fears of many providers, patients may still receive beta-blockers with a heart rate in the 60s." Likewise, the hypotension contraindication applies for systolic blood pressures below 100 mmHg, Vega says. "Providers sometimes withhold beta-blockers for systolic blood pressure in the 110s or 120s, but many of these patients can still safely be given the medicine."

Standing orders

Use standing orders or order sets that prompt for the use of beta-blockers in the absence of contraindications, he suggests. At York Hospital's ED, when an AMI patient arrives and the initial care is completed, the nurse or physician pulls the order set as soon as possible. They then consider treatments such as beta-blockers, says **Donna Fitz**, RN, MS, CEN, SANE-A, clinical nurse specialist for the ED. "The contraindications are discussed with the physician," she says.

ED nurses were notified of the study's findings via e-mail to raise awareness about patients at risk for not receiving beta-blockers, says Fitz. "This is getting more attention in our ED," she says. "We are educating our nurses by informal discussion with physicians, which increases the frequency of the use of beta-blockers."

Reference

1. Vega DD, Dolan KL, Pollack ML. b-Blocker use in elderly ED patients with acute myocardial infarction. Presented at the Society for Academic Emergency Medicine's New York State Regional Meeting. New York City; March 31, 2004. ■

HOSPITAL CASE MANAGEMENT™

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

2006 Index

Access Management
- Initiatives cut write-offs, improve compliance, MAR:46
- Targeting unbilled accounts, FEB:27
- Technology can help with ED overcrowding, MAY:76

Ambulatory Care
- HHS considers new reimbursement system, JUN:94
- Patient safety goals affect ED nursing, SEP:142

Avoidable Delays
- Team conferences help CMs, MDs agree, FEB:20
- Tracking delays improves patient flow, DEC:181

Caring for the Uninsured
- CMs help unfunded patients avoid hospitalization, JUN:89
- Dedicated social worker finds placement for homeless, JUL:100
- Discharge planning for the homeless, JUN:81
- Network uses creativity with unfunded patients, JUN:83
- Programs helps indigent find a PCP, JUN:85
- Staff donate to provide care for the needy, JUN:86
- Use creativity in DP for undocumented workers, JUL:97

Discharge Planning
- Discharge by appointment maximizes capacity, OCT:159
- Flexibility is key to patient throughput, APR:61
- Getting patients into the right admission status, JAN:11
- Keep discharge planning basics in mind, OCT:156
- Make sure patients understand discharge plan, MAR:33
- Multidisciplinary approach results in timely discharge, JUN:91
- Post-discharge placement for the homeless, JUN:81
- Proposed Medicare discharge rule draws fire, JUL:110

Disease Management
- CHF project bridges gap between providers, JAN:13
- Helping the mentally ill remain in the community, JUN:87
- Hospital-based program cuts admissions, JAN:7
- Initiative takes aim at infant mortality, AUG:126
- Program follows CF patients through continuum, MAY:70
- Stroke program winds Codman award, FEB:29
- Young cancer patients present challenges, FEB:31

Documentation Enhancement
- Documentation specialists track core measures, DRGS, SEP:135
- Program generates $1 million in additional revenue, AUG:118
- Team approach to documentation pays off, OCT:151

Emergency Department Case Management
- CMs can help avoid crowding, diversion, SEP:129
- Creating care plans for frequent flyers, FEB:22
- Program steers indigent patients to PCPs, JUN:85
- Relieving the ED bed burden, JUL:105
- Tiered structure improves flow, satisfaction in ED, MAR:42
- Using technology to eliminate bottlenecks, MAY:76

Employee Health
- JCAHO creates flu immunization standard, AUG:128
- Organization pushes mandatory flu shots, AUG:121

Geriatric Care
- Geriatric care managers help seniors stay at home, OCT:153
- Unit improves outcomes for elderly, JUL:107

Health Care Literacy
- Help fill patients' "perception gap": MAR:36
- Low health literacy contributes to readmissions, MAR:33

Patient Safety Alert
- CDC Updates TB prevention guidelines, APR:2
- Health care disparities narrowing, APR:2
- Quality, safety improving at modest pace, APR:1
- Workers' flu shots can save patient lives, JAN:1

Patient Throughput
APNs ensure patients receive timely care, OCT:149
Dedicated team coordinates trauma patient care, SEP:133
Initiative cuts average length of stay, JUL:103
Initiative improves patient throughput, SEP:132
Keep discharge planning basics in mind, OCT:156
Navigators guide patients through the continuum, APR:54
Take the lead in moving patients through the continuum, MAR:39

Performance Measurements
Case managers can take lead in CMS initiative, MAY:65
CM outcomes prove your value, FEB:17
Dashboard helps hospitals focus on core measures, MAY:71
Dedicated staff improves core measures compliance, DEC:187
Documentation specialists track core measures, DRGS, SEP:135
Don't collect data that you no longer need, JUL:105
Eliminating roadblocks to core measure compliance, OCT:148
Scorecard tracks trends in LOS, readmissions, MAY:72

Physician Advisors
MD-CM collaboration cuts LOS, JAN:4
Work closely with physician advisors to improve care, JAN:1

Process Improvement
Initiative cuts vent days in half, JUL:101
Initiative improves patient throughput, SEP:132
Help prevent medication errors, NOV:165
Reorganization improves reimbursement, AUG:117
Take a fresh look at work practices, MAR:43
Unit focuses on short-stay cardiac patients, APR:52
Wireless laptops improve efficiency, NOV:169

Professional Development
LTACHs offer opportunity for true case management, MAY:68
Successfully managing your time, SEP:139

Quality Improvement
Automatic handoffs could cause errors, FEB:24
CMs handle quality initiatives, NOV:167
CMs take the lead on initiatives, APR:55
Dashboard helps hospitals focus on core measures, MAY:71
Keeping staff on track with neuro patients, FEB:23
"Lean Production" saves money, JAN:8
Outcomes managers improve patient care, safety, MAR:37
Pay-for-performance opportunities, MAY:65
Report outlines "quality chasm" MAY:74

Regulatory Issues
Be vigilant on fraud/abuse compliance, OCT:155
CMS plans changes to EMTALA, OCT:154
Complying with JCAHO's patient flow standards, MAY:79
JCAHO surveyors increase requirements for improvement, AUG:119
JCAHO to examine patient handoffs, JAN:9
JCAHO's National Patient Safety Goals, SEP:142
Meeting JCAHO's medication labeling goal, MAY:73
Take a role in medication reconciliation efforts, NOV:161
Team approach to medication reconciliation, NOV:164

Reimbursement
CMS revamps hospital payment structure, AUG:113
Don't rely on Condition Code 44 to fix mistakes, JAN:5
DRG changes on the way, OCT:145
Get involved in insurance negotiations, JAN:6
New codes for observation status, APR:49
New DRGs may affect your hospital's reimbursement, APR:51
Obtaining copays from unscheduled patients, JUN:90
Proactive approach cuts denial rate, NOV:166
Program boosts copay collections, APR:57

Rural Case Management
One-person departments have many roles, AUG:116
Thinking outside the box is critical, AUG:113

Staffing Issues
Create an environment where CMS can thrive, SEP:137
Education program for new CMs, DEC:177
Make staff feel appreciated during CM week, SEP:138
Training and competency for case managers, DEC:180