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Feeling frustrated and challenged by your job? You're not alone

Changing roles mean a shift in outlook

In today's health care arena, case management duties and job descriptions are changing rapidly, often resulting in feelings of frustration and disconnection among case managers in the managed care industry.

"Case managers on the payer side have always felt somewhat disconnected because, primarily, their contacts with clients are by telephone," says **Sandra Lowery**, RN, BSN, CRRN, CCM, CNLCP, president, Consultants in Case Management Intervention, a Francestown, NH, health care consulting firm specializing in case management.

In the past decade, the case management arena has shifted from on-site case management to more telephonic case management.

The problem has been exacerbated in recent years because of caller ID, do-not-call lists, and increased insurer distrust that make it more difficult than ever to reach their clients, Lowery reports.

"This is another challenge because they feel more disconnected. When they are calling clients, they don't necessarily reach them," she says.

At the same time, case managers in the managed care industry are being asked to do other jobs instead of case management, including quality improvement initiatives and disease management roles, such as health coaching, that are not a traditional part of the case management role. They must learn new skill sets, such as predictive modeling and motivational interviewing and are being asked to do more data entry and analysis than in the past.

"There has been a huge leap in terms of the identity of the case management role, and the new skills that case managers need are a big challenge," Lowery adds.

Case managers should make sure their employers are aware of the national standards of practice for case management and base the case management role on those standards.

"Case managers should make sure that there are separate job descriptions for the different hats they wear. If they're doing disease management

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and not case management, they should make sure that there is a job description for what they do," she says.

Case managers have told **B.K. Kizziar**, RN, CCM, CLCP, that they are so pressed with other tasks that they don't have the time to build relationships with their clients.

"The case management job has become more task-oriented than process-oriented, whether it's due to the legal requirements, accreditation requirements, or the requirements of the governing entity. Case management has lost that patient relationship piece and has become mostly about data collection," says Kizziar, owner of BK & Associates, a case management consulting and life care planning company based in Southlake, TX.

That's what **Marcia Diane Ward**, RN, CCM, experienced when she decided to return to case management after a career in information technology.

"When I pioneered as a managed care case manager in the late 1980s, insurance companies seemed to value nurse case managers and to realize that they bring a wealth of information to the table. The focus was always cost-oriented; but in the old days, there was more respect for nurse case managers as a professional and an educated decision maker," she recalls.

When Ward began interviewing at managed care companies, she found that the case management role had changed. She took a job with a major firm but left a month later after spending much of her time negotiating out-of-network fees.

"Basically, case managers are just managing the benefits. They are making sure patients get out of the hospital on time and looking at length of stay. These are case management functions, but it seems to be very unimportant to the managed care organizations for the case managers to have direct contact with the patient. They tend to see it as a waste of time," Ward explains.

One potential employer told her that if she did get in touch with patients, she was to use a script that they provided.

"This leaves no room for the nurse case manager's judgment. Case managers used to manage their own cases. It's a great reward when we can have good coordination of care, good outcomes, and save money along the way," she says.

If health plan members know to ask for a case manager and do so when the need arises, the impetus will be on the managed care organizations to put the role of patient advocate back into the case management job description, Kizziar points out.

"The future of case management universally depends on our ability to build relationships with the community. The highest form of advocacy is to inform the public of our services. If people don't know what a case manager is and what services they provide, they don't know to ask for one," she says.

When Kizziar develops programs for providers, she promotes the idea of telephonic contact with the insured on a routine basis.

"I do a lot of case management program development and always emphasize that we can be more successful in meeting our objectives by creating and nurturing relationships with patients," she adds.

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Part of the case manager's role as an advocate is to educate clients as to what their benefits are and how they can best use them.

"The opportunity to build a relationship on a positive note gives the case manager an element of satisfaction they don't get through e-mail, voice messaging, or paperwork," Kizziar explains. "We're such a techno-savvy and techno-reliant industry that we have a tendency to spend a great deal of time on the latest technology that can save us time. In many cases, we've taken the patient out of the equation," she laments.

Often, the first time the insured hears from a case manager is with bad news, that the treatment their physician has recommended isn't covered by their benefit, Kizziar says.

"We've come a long way in changing the perception that the only things payers want to do is cut benefits and save money, but when we take the personal relationships out of it, you've lost a significant piece of what health care can be about," she adds.

When case managers take the time to let a member know who they are, giving them a name and a phone number and checking back with him or her routinely, it builds a relationship that may prevent resentment when the benefit won't cover something. "If the insured knows who we are, if they hear a voice and have a name, the ability to change behavior in disease management increases because they're talking to someone they know, rather than an anonymous caller," Kizziar says.

Today's case managers are doing far more than in the past, with increasing caseloads to boot, Lowery says.

They are working with predictive modeling tools, and their work is geared toward primary prevention as well as secondary prevention of chronic diseases.

Many case managers are very frustrated with the new skill sets that their job requires, such as health care coaching to prevent exacerbation of chronic diseases, Lowery says.

"Coaching has always been a part of case management, but it's now on a different level," she says.

Insurance companies are providing training for motivational interviewing and health coaching, but the training is usually short and doesn't give the case managers the skills they need for the job, Lowery says.

"Four hours of training isn't enough. This is a whole new skill case managers need to acquire and not one they got in nursing school. Companies should realize that some people are not comfortable with that function and may need some mentoring beyond training," she says.

Caseloads continue to be a major challenge for case managers, Lowery says.

"We don't have any national benchmarks, so each organization tries to interpret blindly what the caseload should be," she says.

Since there are few benchmarks for caseloads, encourage your organization to do time studies in order to base caseload assignments on objective information and to base caseloads on the acuity levels of the members being managed, she adds.

Case managers should remember that their main role is that of advocate and educator, Kizziar says.

"Over and over again, when I talk to case managers I ask how many know how many home health visits their benefits allow or what the annual dollar benefit for home health is. Rarely do more than 1% or 2% raise their hands. If we, as case managers and health care professionals, don't know our benefit, how can we expect our clients to know?" she asks.

While case managers need to be computer-savvy and understand the nuances of today's health care arena, they also need to develop good communication skills in order to do their jobs well, Kizziar says. ■

P4P program rewards providers for quality

Hospitals, physicians can earn extra reimbursement

With the goal of boosting outcomes for health plan members, BlueCross Blue Shield of South Carolina has developed a pay-for-performance program open to hospitals and physician groups in the network.

"We are focusing our attention on physicians and hospitals around quality initiatives and improving outcomes for our members. This ultimately will lead to better quality and lower costs," says **John Little**, MD, vice president of health care services and chief medical director for the Columbia-based insurer.

Officials at the health plan have been studying the pay-for-performance movement in the health care industry and decided to bring its own program into the market, calling it "performance recognition," he says.

"One goal for this program is to make hospitals and physicians comfortable with the idea of

pay for performance and what it could ultimately mean. We want them to understand that we and other commercial payers are joining Centers for Medicare & Medicaid Services [CMS] in moving in that direction and that we plan to focus on rewarding providers who improve quality and ultimately lower costs," Little says.

The program is voluntary and open to any physician group or hospital in the network.

"Our intent is that the program will evolve as time goes on and we get better reporting and better data. We have made it clear to the provider community that this is not a static program and that this pilot project will evolve in the next 18 to 24 months," Little says.

Designing the program

In designing the program, the health plan looked at initiatives that would be meaningful to its members and have an impact on its population. Because South Carolina has a high prevalence of heart disease, diabetes, and stroke, the physician initiatives focus on those three diagnoses.

Under the program, physicians will receive a one-time cash award of up to $5,000 for achieving either National Committee for Quality Assurance (NCQA) accreditation for diabetes or cardiovascular disease or certification in hypertension management by the American Society of Hypertension.

"We chose NCQA because they focus on the disease areas we are interested in; the accreditation program is nationally developed and administratively doable for physician practices whether or not they have a sophisticated computerized medical record in their office. We added the American Society of Hypertension program to fit in with the South Carolina Hypertension Initiative," Little says.

The hospital portion of the performance recognition program has three parts:

1. Hospitals will receive an increase in reimbursement (around 0.5%) for a year if they achieve the 90th percentile nationwide for any four of the 10 quality measures tracked by CMS quality initiative program.

2. Hospitals that participate in the Leapfrog Group Hospital Quality and Safety Reporting Program will receive a similar increase in reimbursement.

3. Hospitals that fully implement a computerize physician order entry (CPOE) system will receive a one-time reward of $50,000.

While most of the interest in the physician recognition program has come from primary care physicians, the health plan offers the reward to a physician of any specialty who is accredited by one of the programs or passes the test.

In the first three months of the program, nearly 20 physicians and physician practices qualified.

"We have seen a moderate amount of interest from other physicians. We've gotten some comments that it is more appropriate for primary care physicians and doesn't cover every specialty. We knew that going in but wanted to start with something that is broadly applicable and meaningful to our membership," Little adds.

Accreditation from the NCQA involves reporting and chart-audit functions. To receive the designation of Clinical Specialists in Hypertension from the American Society of Hypertension, physicians have to take a course and pass an exam.

"These initiatives do take some effort. We made the reward high enough to catch the attention and interest of the physicians and to give them an economic incentive to cover the administrative cost of accreditation," Little says.

So far, one hospital has met the criteria for the CMS Core Measures performance, and there has been a substantial increase (from five to 14) in the number of network hospitals that report the Leapfrog quality and safety measures.

"This initiative got the attention of the hospitals and encouraged them to make a decision about reporting the Leapfrog measures," Little says.

So far, no hospital has completely implemented its CPOE system according to Leapfrog standards.

The health plan chose the quality measures because they would be administratively simple to track and wouldn't add to the workload of the providers or the health plan.

"We didn't want to create an industry of measurement that would require physicians and hospitals to do a lot of reporting and the health plan to do a lot of data analysis," he says.

The health plan chose national recognition measures, rather than a measurement system developed locally, so physicians and hospitals would feel confident about the nationally known standards.

"We wanted to leverage off existing quality initiatives for diabetes and cardiovascular disease," he adds.

Before embarking on the program, the health plan mailed a description of the program and an agreement to every hospital with which it contracts. The material outlines what the hospital

must do to qualify. If they choose to participate the hospitals send in a signed agreement and list what criteria they met and the dates they met it.

The health plan's staff go to the CMS and Leapfrog web sites and ensure that the criteria have been met.

Physicians received a similar mailing and must send in a signed agreement along with an accreditation certification certificate. As an alternative, physicians may send in the date they were certified and the insurer will check the NCQA or American Hypertension Association web site.

Once the health plan receives a confirmation that the criteria have been met, it implements the process for the provider to receive the cash award. ■

CHF project aims to bridge gap between providers

Ultimate goal is better outcomes, fewer readmissions

Drawing on 20 years of quality improvement experience, MPRO, Michigan's Health Care Quality Improvement Organization, is bringing together hospitals, home health agencies, and physician practices to come up with solutions to communications barriers between providers, with the ultimate goal of improving the outcomes for the state's cardiovascular disease patients.

"In the state of Michigan, no one has brought different groups from across health care setting together at one table. This pilot project is the first time that hospitals, home health agencies, and physician offices come together to work together for better patient outcomes," says **Linda Charles**, RN, BS, project coordinator for MPRO's hospital quality improvement team.

MPRO has been awarded a contract with the Michigan Department of Community Health for the pilot project "Cardiovascular Health Project." The goal is to reduce the number of hospital readmissions for patients with cardiovascular disease, especially congestive heart failure (CHF) by reinforcing education and self-management before and after hospitalization.

The project aims to improve the consistency of documentation, patient assessment, and reporting of clinical findings and to close the gap between the hospital, home health agencies, and physician offices.

"The goal of the heart failure collaborative across settings is not just to decrease readmissions. Other goals are to reinforce heart failure patient education and self-management prior to and after hospitalization and to help the patients gain more control over the disease process," says **Teri Aldini**, RN, MS, project manager for the home health and hospital team.

Heart failure is the leading diagnosis for Medicare patients in the state of Michigan and is among the leading diagnoses for hospital readmissions.

The 325,000 patients discharged with a diagnosis of heart failure last year incurred approximately $226 million in hospital costs. About 25% are discharged from Michigan hospitals with a home health referral.

"When we worked on cardiovascular quality improvement projects in the past, our team had observed the disconnect between the hospital, the home health agency, and the physician office. We wanted to create a collaboration between the hospitals and home health offices, realizing that the physician's office is an integral part of post-acute care," Charles says.

The disconnect appears to occur when patient care is managed by a cardiologist while the patient is hospitalized and following the patient's discharge home, care is then resumed by the primary care physician.

Typically, the cardiologist will discharge the patients to home with home health and the patient receives post-discharge instructions from the hospital but it takes a while for the discharge summary to reach the physician's office. If the patient has a question or an acute event or the home health agency calls for further orders, the physician does not have the information he or she needs to prescribe follow-up care.

"Even if a primary care physician assumes care in the hospital and writes a home health referral, he has the knowledge of what happened in the hospital but the office staff may not, and they are the ones who typically triage the patients," Charles says.

The project aims to integrate care across all settings to improve patient outcomes by bringing together hospitals, home health agencies, and representatives from physician offices for two intensive learning sessions during which the providers share ideas about improving communication.

"We serve as facilitators at these sessions, bringing different stakeholders together and giving them the opportunity to identify where the problems are and work on solutions to overcoming barriers. It's

the responsibility of the providers to adapt the lessons they learned when we were together and change the process of care in their individual settings," Charles adds.

MPRO holds a monthly conference call in which participants report on what they have implemented.

Participants include hospital and home health quality improvement staff, home health administrators, hospital discharge planners and offices managers, and sometimes nurses from physician practices. The pilot project with the Michigan Department of Community Health involves two hospitals, three local home health agencies, and four physician practices.

Other initiatives

The organization has led a number of other cardiovascular quality improvement initiatives, including the Michigan Heart Failure Discharge Documentation program, developed with Blue Cross and Blue Shield (BCBS) of Michigan and the Michigan chapter of the American College of Cardiology.

The aim of the project is to ensure that admission and discharge orders meet the Core Measures for quality established by the Centers for Medicare & Medicaid Services (CMS) and the Joint Commission on Accreditation of Healthcare Organizations.

"Heart failure discharge instruction rates throughout the nation are extremely poor. Those statistics, coupled with the fact that heart failure represents a significant health care expenditure, is what precipitated this project," Aldini says.

The team brought together 39 participating Michigan hospitals for intensive learning sessions and sharing ideas to make sure the quality initiatives are being met.

"The goal of the program was not just to increase the rate of discharge instructions documentation but to increase patient knowledge and to give the patients more tools to help them control their disease process and adapt their lifestyles," Aldini says.

The hospitals received a template document designed to improve the documentation for the six core measures for heart failure and were encouraged to use it or adapt it.

MPRO followed up with conference calls in which hospitals reported their use of the tools provided.

As a result of the project, hospitals in Michigan have begun sharing tools that help them address the Core Measures and other quality initiatives, Aldini says.

The project has improved heart failure discharge instruction documentation significantly. The baseline measurement showed that an average of 50% of hospitals were meeting the Core Measures for heart failure. After a year, the average rose to 68%. Following on the success of the initial project, MPRO, the Michigan chapter of the American College of Cardiology and BCBS of Michigan are expanding the program statewide and held their first learning session in October. ■

Administrative support helps keep LOS low

ED keeps close tabs on patient flow

There are times when EDs can achieve dramatic improvements in average length of stay (ALOS) or reductions in their left without being seen (LWBS) percentages in a relatively short period of time by instituting significant new process improvements, such as bedside registration or new triage protocols. That's not, however, the only way to achieve excellence in these areas — and it may not even be the best, according to some experts.

At Wilson Memorial Hospital in Sidney, OH, for example, ALOS is 78 minutes and LWBS is one in 300 patients, but that has been par for the course at Wilson Memorial for quite some time. "For a number of years, we've had very low treat and release times," says **Linda Maurer**, RN, director of critical care services. She says such ongoing excellence is due to a combination of factors at Wilson. "Nursing is a piece of it, but most of [the credit] goes to administrative support," she says.

Fred Haussman, MD, the ED's medical director, agrees. "I've been here 20 years, and would not still be here if they were not supportive," he says. "The most important thing is they understand the importance of the ED as the 'front door' to the hospital." In fact, he says, that support "is stronger now than I can remember."

The ED keeps very close tabs on their patient flow and shares it with administration, adds Maurer. "We are very data-driven; we carefully track our hours per patient," she explains. "When the load goes up, we take those numbers to them, and they support our adding staff."

The ED is approaching 30,000 visits per year, according to Haussman. "We have seven full-time ED docs that staff the ED and are part of Premier Healthcare Services, which is contracted to provide emergency services," he says. There are 38 full-time equivalents (FTEs) in the ED, including 52 RNs, patient care technicians, and secretaries.

ED patients have priority

Haussman and Maurer agree it takes much more than a supportive administration to achieve and maintain such numbers. Premier also is partially responsible, notes Haussman. They provide the proper physician staffing in the ED at the right time, he says.

"We do not run three-fourths patient-per-hour volume like some EDs get pushed into," Haussman explains. "Premier will provide us with the proper number of physicians so they aren't all running around and not providing good care."

Also critical is the staff's willingness to take on additional roles within the department, he says. "There's a good deal of cross-training in our staff," Haussman says. "They go to inservices and have to pass a proficiency test to be allowed to perform different tasks."

At Wilson Memorial, they do all their own phlebotomy within the ED, Maurer says. "We draw the blood ourselves, print the label, and take it to the lab," she reports. They do all of their own 12-lead EKGs, so they don't have to wait for a physician. "Anything we can come up with and do ourselves, we go with."

All the ED patients have priority over outpatients,says Maurer. "All the labs automatically run STAT when tests come from the ED," she says.

The cross-training saves a great deal of time, she says. "We couldn't get patients in and out if they had to wait for an hour and a half for urine and X-ray," Maurer explains.

Support from other departments is critical, Haussman says. "If we did not all work efficiently together, we would not have success."

So much for 'fast' track

One of the more significant single timesavers for the ED, ironically, was the discontinuation of a fast-track triage service, says Haussman.

"We used to have it to try and separate out minor cases in the evenings, and triage the patients into a separate area next to the ED," he recalls. It sounded wonderful, but they never could get triaging to work quite right, Haussman says. "When they were busy, we weren't, and vice versa," he says. "We saw a real success when we moved into our new ED in 1997 [and discontinued fast-track.]"

Haussman says he's been able to bring both the physician from the fast-track and the one from the traditional ED into the ED in the evenings now, and all patients are seen through the ED.

The goal is not to increase LOS for ankle sprains, Maurer emphasizes. The LWBS was higher when they had fast-track, Haussman says. "A lot of people would come in at a certain time, and we'd get a huge bolus of patients who could not all be accommodated, so people would leave and come back the next day," he says.

Today, Wilson Memorial's LWBS averages fewer than five patients a month, says Maurer. ■

Hospices, hospitals focus more on palliative care

Even a freestanding hospice can make it work

Palliative care programs are growing in number and prominence at hospitals and hospices across the nation, as increasing numbers of health care providers want to focus on medicine used as much for comfort and quality of life as for diagnoses and cures when dealing with patients who have chronic illnesses for which there are no easy resolutions.

The number of hospital-based palliative care programs nearly doubled between 2000 and 2003 to 1,100, and now about 1,800 physicians have become board-certified to participate in palliative care, reports **Amber Jones**, BA, M.Ed, hospice liaison consultant at the Center to Advance Palliative Care (CAPC), based at Mt. Sinai School of Medicine in New York City.

There also has been an increase in the number of nurses specializing in palliative care, she adds.

There are about 200 certified advanced practice nurses now, and soon there will be more, Jones says. "There also are licensed nursing assistants in palliative care, and so we're seeing a huge growth in the number of palliative care trained professionals," she adds. "We did a survey of

hospices 2½ years ago, asking how many were interested in providing palliative care services, and 25% were already offering palliative care services, and 90% were in the process of planning it."

For hospices, the move to palliative care is a natural one, says **LaDonna Van Engen**, RN, CHPN, hospice program coordinator of Saint Elizabeth Hospice of Saint Elizabeth Regional Medical Center in Lincoln, NE.

"In order for hospices to survive with Medicare and Medicaid and insurance, we need to promote and look at palliative care," she says. "It offers people the control they want."

Chronic care

Palliative care is becoming an attractive service for patients with a wide variety of chronic diseases, including congestive heart failure, emphysema, peripheral vascular disease, and end-stage heart disease, experts say.

The concept is directed toward supportive care for patients who have symptoms that are not well controlled, medication side effects that have led to a poor quality of life, and chronically ill patients who are not terminally ill.

For instance, a person with advanced heart disease might be routinely shuffled into surgery, but the palliative care approach would have a team help the patient look at the quality of life risks of such surgery and make a decision that, while not ideal, may be better suited to their needs and situation, Van Engen says.

Van Engen says under the palliative care approach, she would say to the adult child of an 80-year-old patient whose health is failing rapidly, although no one disease qualifies as a hospice referral, "Tell me about your mom. What kind of person is she? Would she want you to do everything to keep her alive like this, and can she get better?"

"When someone is facing a serious chronic or life-limiting illness, they also have a lot of emotional issues, and they need to make decisions about what they want with the rest of their life," says **Cindy Marsh**, executive director of the Hospice of Texarkana (TX) Inc., a freestanding, community-based, nonprofit hospice that provides palliative care services.

"They may need to make advanced directives and those types of things are addressed with the social worker on the team," she says.

Likewise, the social worker will help palliative care patients understand what will happen when they're discharged from the hospital."

So the biggest question hospices have with regard to palliative care isn't whether to provide these services, but how, Jones says.

CAPC answers the how question by providing educational programs that help health care providers build a business plan and gain support for the utilization of palliative care services, she explains.

One program is a two-day intensive seminar that provides a primer on building a palliative care program with lectures, small group sessions, and the goal of providing attendees with an understanding of the elements of the program, Jones says.

CAPC also offers site visits at one of the organization's six palliative care leadership centers, at a cost of $1,500 to $1,750 for four people. A health care team may visit a center over a two- to three-day period to gain hands-on experience with people who have been through it, Jones explains.

The team typically brings to the site visit data from the hospice or hospital, which can be used in developing a business and implementation plan, she adds.

As a follow-up, the visiting teams receive a year of technical support from the leadership center. The Hospice of Texarkana formed a palliative care program after staff received training from CAPC, Marsh reports.

The palliative care initiative is two-pronged: The first and main effort involves a collaboration with CHRISTUS St. Michael Health System in Texarkana, and the other effort will be the opening of an outpatient palliative care clinic at the hospice medical director's clinical setting, she says.

"We had been working with CHRISTUS for some time in providing hospice services, and we had gained their trust in both our clinical operations and in how we conduct business with our patients there in the facility," Marsh says. The hospice's mission was helped by CHRISTUS leaders who wanted to implement palliative care services in all of the health system's facilities, she notes.

"What made this effort extremely successful is the fact that CHRISTUS contracts from us a nurse liaison who is working with case management on a daily basis to identify patients who might benefit from a palliative care consult," Marsh says.

The Hospice of Texarkana program also involves a social worker and doctorate-level pharmacy consultants, she says.

Palliative care contacts with patients and families

involve at least two disciplines with the goal of making it a team meeting, Marsh reports.

"I think one of the real strengths of a palliative care program can be continuing the interdisciplinary approach that is so successful in hospice," she says.

For hospices that already are part of a hospital system, palliative care is a natural fit both clinically and economically.

For example, Saint Elizabeth provides some of the same comfort and support for patients and families referred to palliative care services as those referred to hospice, although the palliative care patients do not have to have a diagnosis of fewer than six months to live.

"We provide comfort care on things besides healing," says Van Engen.

Palliative care patients must meet Medicare guidelines for home care services, but they receive home care with the additional comfort and support that palliative care offer, she says.

"Medicare doesn't recognize palliative care in the home at this point," Van Engen adds. Hospices that have home care services or are affiliated with health systems with home care services train home care staff to provide a palliative approach to their care, she explains.

"The staff don't just provide wound care, but focus on end-of-life issues, family support, and that sort of thing," Van Engen says. "With the palliative approach, the home health aide may say, 'I'm going to give them a bath, but if they insist on not getting up today, I won't push that hard.'"

The benefit to the hospital system is that referring chronically ill patients referred to palliative care services helps to reduce rehospitalizations and saves health care dollars, Van Engen and Marsh note. ■

ICU patients at risk for preventable errors

AHRQ study puts spotlight on adverse events

Patients face a significant risk for preventable adverse events and serious medical errors in hospital critical care units, according to a study sponsored by the Agency for Healthcare Research and Quality (AHRQ). The study, "The Critical Care Safety Study: The incidence and nature of adverse events and serious medical errors in intensive care," was published in the August issue of *Critical Care Medicine*.[1]

The researchers found that more than 20% of the patients admitted to two intensive care units at an academic hospital, a medical intensive care unit (MICU), and a coronary critical care unit (CCU) experienced an adverse event. Of the adverse events in the sample, almost half (45%) were preventable. A significant number of the adverse events involved medications — most commonly, giving patients the wrong dose. More than 90% of all incidents occurred during routine care, not on admission or during an emergency intervention.

The researchers conducted direct continuous observations in the MICU and CCU during nine three-week periods, distributed throughout 12 months from July 2002 through June 2003. This was supplemented by confidential incident reporting, a computerized adverse drug event detection monitor, and chart reviews.

This study was part of a larger research effort examining the effect of eliminating extended work shifts and work hours on serious medical errors by interns, explains lead author **Jeffrey M. Rothschild**, MD, MPH, assistant professor of medicine at Harvard Medical School, and a member of the division of general medicine at Brigham & Women's Hospital in Boston. "This was a secondary analysis," he says. "The method was we followed the interns but reported any errors we found."

While noting that the findings may not be generalizable because Brigham & Women's is a teaching hospital, he adds that "we have certain built-in elements that reduce errors, like computerized physician order entry [CPOE], pharmacists participating on rounds, and full-time attendings in the unit. But to counterbalance that, [patients in the ICU] unit may be sicker than in other places, so the number of events may not be generalizable."

The findings are nevertheless important, he continues, because critical care units provide an increasingly greater proportion of care. "During our lifetimes, we can expect to be admitted to an ICU at least once. We hope these findings will stimulate the adoption of known interventions, like ensuring hand washing, better physician/nurse communications, and greater use of health IT," he says.

Results not surprising

Rothschild asserts that the results (i.e., 45% of the adverse events being preventable) are "quite

consistent with the research we've seen elsewhere."

What did surprise him slightly, he says, was that most of the errors were the kinds that could easily be fixed. "They involved lapses in care — forgetting to do the right thing, forgetting to start certain meds, or slips in which [the provider] incorrectly ordered something because they entered the wrong amount or ordered it for the wrong patient," he notes. These types of errors, he points out, can be more easily corrected than things like making the wrong diagnosis, or problems associated with procedures.

Perhaps equally surprising is the fact that a little over 60% of the adverse events involved medications — most commonly, giving patients the wrong dose. With all the national attention being given to medication safety, is Rothschild concerned we are we still not making progress? "There isn't really hard data to prove it, but we do have a general sense that patient safety is more on the minds of clinicians, and the hospitals are taking a closer look at what kinds of interventions have worked," he asserts. "In general, most hospitals are making a better effort to identify opportunities for improvement; I have a sense we are going in the right direction, but we have a real long way to go."

It is Rothschild's hope that these findings "will stimulate the adoption of known interventions" to reduce errors in the future.

Technological opportunities

Improving communications among clinicians and between disciplines is a clear opportunity, he continues. "Everyone who's caring for the patient should share the same mental model and view of what's going on with that patient and should develop more teamwork in the units," he advises. "Another element is really pushing protocols and compliance with protocols."

One surprising finding, for example, was how often sterile procedures were done without complete sterile techniques. "Hand washing is still a tremendous problem," he observes. "But there are ways to improve; we now have waterless systems at every bedside, which makes it so much easier than going to the sink. That kind of innovative approach works."

He also sees technological opportunities. "We already have CPOE," he notes. "More [computerized] decision support would protect slips in dosing errors. And there are certainly opportunities in medication administration, with smart pumps and bar-coding, though the data on those are still not strong yet."

Earlier studies also have shown that that extended work hours and fatigue present real problems, he adds, noting that his final take-home message is that the number of critical care patients is expanding. "In many hospitals, a quarter of the beds are in an ICU — and that is certainly where the sickest patients go — so it is an important area to concentrate our efforts on improving safety," says Rothschild.

Reference

1. Rothschild JM, Landrigan CP, Cronin JW, et al.. The Critical Care Safety Study: The incidence and nature of adverse events and serious medical errors in intensive care *Crit Care Med* 2005; 33(8):1,694-1,700. ■

Start with simple steps to cut procedure costs

Tourniquet, disposable stirrup strap not needed

El Camino Surgery Center in Mountain View, CA, always has scored high in all the categories of the study on Knee Arthroscopy with Meniscectomy benchmark study by the Accreditation Association for Ambulatory Health Care's Institute for Quality Improvement. However, a review of their 2004 results showed that the center's cost per case was high, reports **Lisa Cooper**, RN, CNOR, clinical director for the surgery center and a speaker at the most recent annual meeting of the Federated Ambulatory Surgery Association.

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"We were surprised that we were one of the highest cost study participants, and we decided to put together a cost study team to look at the reasons for our high costs," she says.

The team included representatives from the administrative, clinical, and financial departments. "In addition to evaluating a cost analysis for all knee arthroscopies, the team looked at costs by physician," says Cooper. There was a difference from physician to physician in operating room time and supply cost per case, she adds.

The data were necessary to present the findings to the physicians, says Cooper. "We did not identify individual physicians, but we showed the differences in costs related to supplies and operating room time and explained how we were a high-cost provider in a national benchmark study."

"Although a thorough cost analysis includes supplies, operating room time, allocation of salary and benefit costs, allocation of monthly overhead charges such as rent, and allocation of indirect costs such as equipment, when we presented the information to the physicians, we focused on costs over which they have control," says **R. Craig Lind**, managing director of Lind/Fitzsimons, a Greenbrae, CA-based management consulting firm and a member of the El Camino cost study team.

"These costs included their operating room times as compared to other physicians and their average operating room costs based on the actual supplies used and marked on the preference cards," he explains. They also were careful to include only cases with the same CPT code, in this case CPT 29881, he adds.

It is critical to break down costs by physician because it gives you an opportunity to pinpoint where changes are taking place once you initiate cost savings measures, says Lind. "Our analysis by physician helped put the spotlight on what was a surprisingly wide range of performance statistics," he says. "There was a threefold difference in supply costs between the average for the lowest physician and the average for the highest."

By investigating the cause of the wide range of costs, some very specific initial changes that could decrease costs were identified, Lind adds.

Team members knew they couldn't overwhelm the physicians with a list of changes to supplies and or changes in scheduling, so they picked two items that were noncontroversial that they could change to start cutting costs, says Cooper. "We noticed that in 90% of our knee arthroscopies surgeons were using a 'precautionary tourniquet' that was never needed," she says. "There is not enough bleeding in a knee arthroscopy to require a precautionary tourniquet, so by eliminating this one supply, we saved $4 per case."

A disposable stirrup strap used to prep the leg also was adding $4 per case, Cooper says. "We had no problem getting the surgeons to agree that purchasing a nondisposable leg holder for $100 that could be used in place of the disposable strap made more sense."

In addition to getting buy-in from the physicians, she says nursing staff members also were asked for feedback before changing the tourniquet requirement and the disposable stirrup straps. "It is important to get buy-in from everyone and make sure all staff members understand that these cost savings won't affect patient care."

Cooper's cost study team also noticed that more operating room time was needed when physicians draped their own patients. Physicians were late getting into the operating room if they were talking to family members, and then the

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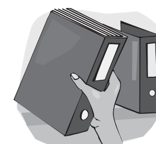

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procedure would start even later as the surgeon draped the patient. "We pointed out to the surgeons that they could spend more time with the patient's family while we draped the patient," she says. "We also developed a competency tool for draping so that the physicians are confident that nurses will drape the patient appropriately."

Cooper admits that the steps her staff members have taken to reduce costs are simple and may not represent a huge savings at this time. "The ultimate goal of our cost savings program is to standardize more of their disposable items so that purchasing contracts with good discounts can be negotiated," she says.

However, the first step they wanted to take was to make everyone aware of the need to save money, Cooper notes. "We knew we had to do this in a way that didn't overwhelm anyone and that would give us an opportunity to present other suggestions for change." ■

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 certificate of completion. ■

CE questions

21. According to B.K. Kizziar, RN, CCM, CLCP, part of the case manager's role as advocate is to educate clients about how to use their benefits.
    A. True
    B. False

22. The physician portion of Blue Cross and Blue Shield of South Carolina's pay-for-performance program focuses on which three conditions?
    A. Asthma, diabetes, and congestive heart failure
    B. Depression, stroke, and chronic obstructive pulmonary disease
    C. Heart disease, diabetes, and stroke
    D. Asthma, heart disease, and depression

23. In Michigan last year, approximately what percentage of heart failure patients were discharged from hospitals with a home health referral?
    A. 13%
    B. 25%
    C. 54%
    D. 62%

24. Approximately how many physicians are now board-certified to participate in palliative care, according to Amber Jones, BA, M.Ed?
    A. 1,100
    B. 1,350
    C. 1,800
    D. 2,300

Answers: 21. A; 22. C; 23. B; 24. C.

CE objectives

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

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

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