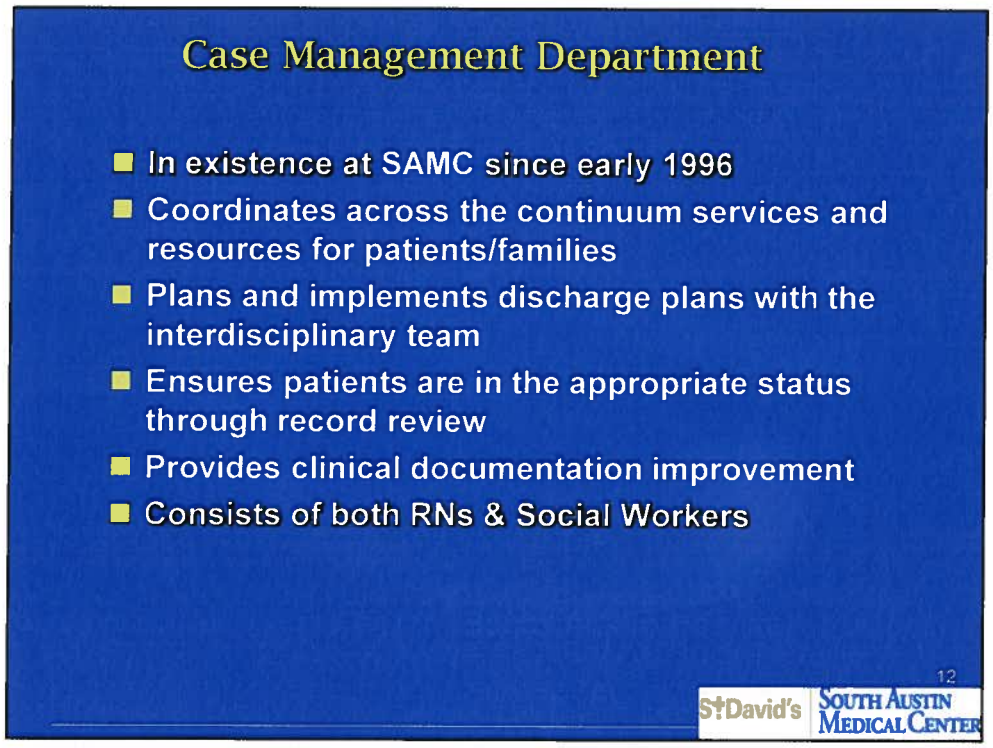
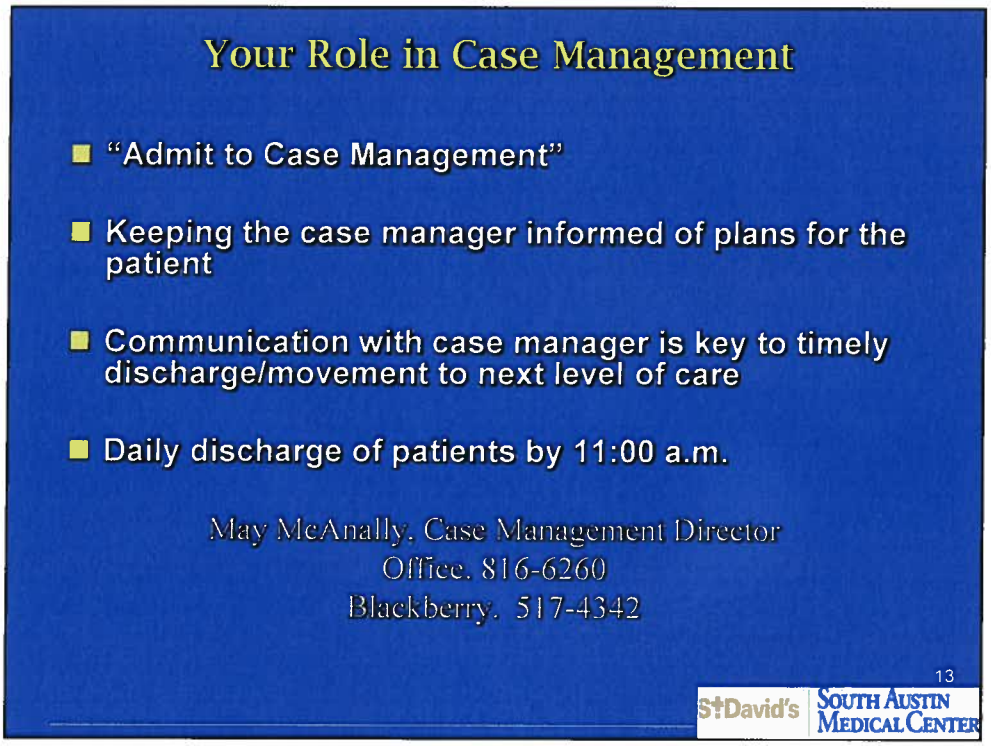


Case Management is responsible for coordinating patient care across the continuum. The goal is to utilize resources efficiently and proactively plan for a realistic, safe and effective discharge plan for all patients while being compliant with federal and payer regulations.

The case managers coordinate services and help patients/families find the available resources that they need by educating them to understand the discharge options. This includes the patient's right to choose a post acute provider such as a skilled facility or home health agency.

The case managers also perform daily reviews to that patients are in the correct status. Appropriate status is key to being compliant with regulations and billing appropriately. Status determinations are made based on nationally recognized criteria (Interqual) and may also include the services of an outside Physician Advisor firm that specializes in reviewing case for compliant status. In addition the case managers communicate with various insurance companies to ensure that inpatient stays are authorized. On occasion you may be asked to speak to a physician from an insurance company or the outside advisor group in a case in which additional information is needed from a physician.

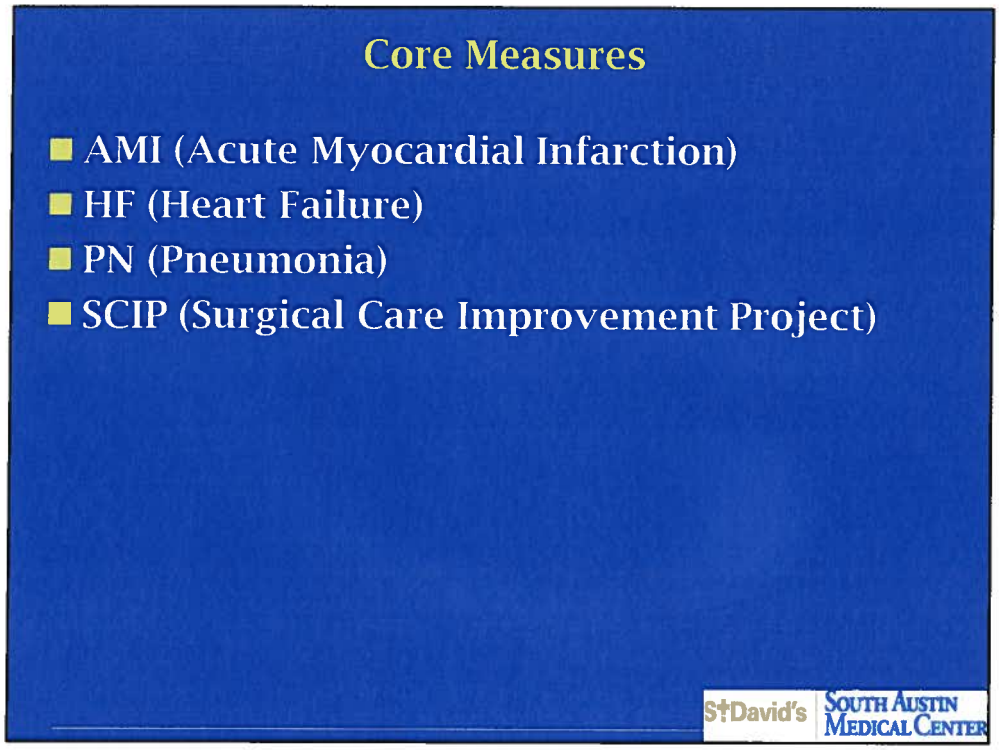
A subset of the case management department is clinical documentation improvement. Clinical documentation Liaisons review records for opportunities to most accurately reflect the patient's severity of illness. This is accomplished by using the nurses' extensive experience to review



To ensure efficient patient care, the case manager will drive the discharge process. Your role is to keep the case manager informed of your plans for your patients so that delays in discharge do not occur. Communication between the physician and the case manager is key to ensure that an appropriate discharge plan is developed prior to the day of discharge. You may be asked to participate in family or team conferences for those patients who offer greater challenges.

Communication with the case managers is key to moving patients through the continuum and to the next most appropriate level of care.

If you have any questions about case management please be sure and ask the director of case management for further assistance and clarification of the case manager's role.



As part of an ongoing process to improve delivery of patient care, South Austin Medical Center participates in four *Core Measures*:

•AMI (Acute Myocardial Infarction)

•HF (Heart Failure)

•PN (Pneumonia)

•SCIP (Surgical Care Improvement Project)

The Joint Commission, in conjunction with CMS, requires hospitals to participate in Core Measures. Reports on hospital compliance to core measure indicators are available through the JCAHO website and publicly through the CMS Hospital Compare website. CMS provides payments to hospitals that meet certain core measure requirements which allow hospitals to purchase equipment, hire more staff, etc.

CMS/JCAHO Requirements

CHF	AMI	Pneumonia	SCIP (Surgical Care Improvement Project)
Discharge Instructions *(Discharge medications listed on the Discharge Summary, Discharge Order and Discharge Instructions must match.)*	**Aspirin at arrival**	**Blood cultures collected before initial antibiotic**	**Antibiotic within 1 hr of incision**
LVS function – EF%	**Beta Blocker at arrival**	**Antibiotics received within 4 hrs of arrival**	**Antibiotic selection** *(per guidelines)*
ACE/ARB for LVSD at discharge *(If LVEF in less than 40%)*	**Primary PCI w/in 90 min**	**Antibiotic selection** *(per guidelines)*	**Antibiotic discontinued within 24 hrs of surgical end time**
Smoking cessation advice/counseling	**Aspirin at discharge**	**Pneumococcal vaccination** *(For pts ≥65 yrs old if criteria met.)*	**Cardiac surgery patients with controlled 6 a.m. blood glucose on POD1 and POD2** *(Blood glucose must be ≤200 mg/dL)*
Heart Failure patient with chronic/ recurrent atrial fibrillation received warfarin on discharge	**Beta Blocker at discharge**	**Influenza vaccination (Oct-Mar)** *(For pts ≥50 yrs old if criteria met.)*	**Appropriate hair removal**
	LVS function – EF%	**Smoking cessation advice/counseling**	**Colorectal surgery patients with immediate post-op normothermia** *(1st recorded temp within 15 min after leaving the OR must be > or = to 96.8°)*
	ACE/ARB for LVSD at discharge *(If LVEF in less than 40%)*		**Cardiac surgery patients on beta blocker therapy prior to admission who received a beta blocker during the peri-op period.** *(24 hours prior to incision through discharge from PACU/Recovery Area)*
	Smoking cessation advice/counseling		**VTE prophylaxis within 24 hrs prior to incision to 24 hrs after surgery end time**

Pneumonia Antibiotic Consensus Recommendations by CMS/JCAHO

Non-ICU Patient

β-lactam (IV or IM) +
Macrolide (IV or PO) **OR**

Antipneumococcal Quinolone monotherapy (IV or PO) **OR**

β-lactam (IV or IM) +
Doxycycline (IV or PO) **OR**

If less than 65 with *no Risk Factors for Drug-Resistant Pneumococcus*
Macrolide monotherapy (IV or PO)

β-lactam = Ceftriaxone, Cefotaxime, Ampicillin/Sulbactam, Ertapenem

Macrolide = Erythromycin, Clarithromycin, Azithromycin

Antipneumococcal Quinolones = Levofloxacin**, Moxifloxacin, Gemifloxacin

ICU Patient

β-lactam (IV) + Macrolide (IV) **OR**

β-lactam (IV) +
Antipneumococcal Quinolone (IV) **OR**

If documented β-lactam allergy:
Antipneumococcal Quinolone (IV) +
Aztreonam (IV)

β-lactam = Ceftriaxone, Cefotaxime, Ampicillin/Sulbactam

Macrolide = Erythromycin, Azithromycin

Antipneumococcal Quinolones = Levofloxacin**, Moxifloxacin

Pseudomonal Risk

These antibiotics would also be acceptable for ICU and Non-ICU patients **with pseudomonal risk**

Antipseudomonal β-lactam (IV) +
Antipseudomonal Quinolone (IV)
(PO Quinolone is allowed for Non-ICU only) **OR**

Antipseudomonal β-lactam (IV) +
Aminoglycoside (IV) + **Either**
Antipneumococcal Quinolone (IV) **OR**
Macrolide (IV)
(PO Quinolone is allowed for Non-ICU only) **OR**

If documented β-lactam allergy:
Aztreonam (IV)+
Antipneumococcal Quinolone (IV) +
Aminoglycoside (IV)
(PO Quinolone is allowed for Non-ICU only)

*** **For patients with renal insufficiency**
Aztreonam (IV)*** +
Levofloxacin (IV or PO)**

Antipseudomonal Quinolone = Ciprofloxacin, Levofloxacin**

Antipseudomonal β-lactam = Cefepime, Imipenem, Meropenem, Piperacillin/Tazobactam

Aminoglycoside = Gentamicin, Tobramycin, Amikacin

Antipneumococcal Quinolone = Levofloxacin**, Moxifloxacin

Macrolide = Azithromycin, Erythromycin

** Levofloxacin should be used in 750mg dosage when used in the management of patients with pneumonia.

Version 2.4 Discharges 4-01-08 (2Q08) through 9-30-08 (3Q08)

Prophylactic Antibiotic Regimen Selection for Surgery Recommended by CMS/JCAHO

Surgical Procedure	CABG, Other Cardiac or Vascular	Hip/Knee Arthroplasty	Colon	Hysterectomy
Approved Antibiotics	Cefazolin, Cefuroxime, or Vancomycin**	Cefazolin or Cefuroxime, or Vancomycin**	Cefotetan, Cefoxitin, or Ampicillin/Sulbactam or Ertapenem†	Cefotetan, Cefazolin, Cefoxitin, Cefuroxime, or Ampicillin/Sulbactam
			OR	
			Cefazolin or Cefuroxime + Metronidazole	
	If β-lactam allergy:	**If β-lactam allergy:**	**If β-lactam allergy:**	**If β-lactam allergy:**
	Vancomycin*	Vancomycin*	Clindamycin + Aminoglycoside, *or* Clindamycin + Quinolone, *or* Clindamycin + Aztreonam	Clindamycin
	or	or	**OR**	**OR**
	Clindamycin*	Clindamycin*	Metronidazole + Aminoglycoside or Metronidazole + Quinolone	Metronidazole

* For cardiac, orthopedic, and vascular surgery, if the patient is allergic to B-lactam antibiotics, Vancomycin or Clindamycin are acceptable substitutes.

** Vancomycin is acceptable with a physician/APN/PA documented justification for its use.

† A single dose of ertapenem is recommended for colon procedures.

SCIP Core Measures

SCIP INFECTION QUALITY INDICATORS

- Prophylactic Antibiotic Received within 1 Hour of Incision (2 hrs for Vancomycin or fluoroquinolones)
- Recommended Prophylactic Antibiotic Selection for Surgical Patients
- Prophylactic Antibiotics Discontinued within 24 Hours After Surgery End Time (48 hrs for Cardiac Surgery)
- Cardiac Surgery Patients with Controlled 6 A.M. Post-op Serum Glucose (<200 mg/dL) post-op day 1 & 2
- Surgery Patients with Appropriate Hair Removal (no razors)
- Urinary Catheter Removed on Post-op Day 1 or 2
- Surgery Patients with Perioperative Temperature Management (active warming intraoperatively or one body temp. > 96.8o within 30 min. prior to 15 min. after Anesthesia End Time)

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VTE Prophylaxis Selection for Surgery Recommended by CMS/JCAHO

Surgery Type	Recommended Prophylaxis Options * (within 24 hrs prior to incision to 24 hrs after surgery end time): ANY OF THE FOLLOWING							
Intracranial Neurosurgery	LDUH	LMWH†	IPC with or without GCS			LDUH or LMWH† with IPC or GCS		
General Surgery	LDUH	LMWH				LDUH or LMWH or Factor Xa Inhibitor w/ IPC or GCS	Factor Xa Inhibitor	
General Surgery with contraindications to pharmacological prophylaxis			IPC	GCS				
Gynecologic Surgery	LDUH	LMWH	IPC			LDUH or LMWH or Factor Xa Inhibitor w/ IPC or GCS	Factor Xa Inhibitor	
Urologic Surgery	LDUH	LMWH	IPC	GCS		LDUH or LMWH or Factor Xa Inhibitor w/ IPC or GCS	Factor Xa Inhibitor	
Elective Total Hip Replacement		LMWH					Factor Xa Inhibitor	Warfarin
Elective Total Knee Replacement		LMWH	IPC		VFP		Factor Xa Inhibitor	Warfarin
Hip Fracture Surgery	LDUH	LMWH					Factor Xa Inhibitor	Warfarin
Elective THR with contraindications to pharmacological prophylaxis			IPC		VFP			
Hip Fracture Surgery with contraindications to pharmacological prophylaxis			IPC	GCS	VFP			

* Pts who receive neuraxial anesthesia or have a documented contraindication to pharmacological prophylaxis may pass the performance measure if either appropriate pharmacologic or mechanical prophylaxis is ordered.

†Guidelines recommend postop LMWH for Intracranial Neurosurgery

Low-dose unfractionated heparin **(LDUH)** Intermittent pneumatic compression devices **(IPC = SCD's)**
Low molecular weight heparin **(LMWH)** Graduated compression stockings **(GCS = TED hose)** Venous Foot Pump **(VFP)**

Version 2.4 Discharges 4-01-08 (2Q08) through 9-30-08 (3Q08)

SCIP Core Measures

SCIP VTE QUALITY INDICATORS

- Recommended Venous Thromboembolism Prophylaxis Ordered anytime from hospital arrival to 24 hrs after *Anesthesia End Time*
- Recommended Venous Thromboembolism Prophylaxis within 24 Hours Prior to *Anesthesia Start Time to 24 Hours After Anesthesia End Time*

SCIP CARDIAC QUALITY INDICATOR

- Surgery Patients on Beta Blocker Therapy Prior to Admission Who Received a Beta Blocker During the Perioperative Period

SCIP HEART FAILURE QUALITY INDICATOR

- *ACEI or ARB Prescribed at Discharge for Patients with <40% LVEF*

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